AmeriHealth Caritas™
Louisiana

Claim Filing Instructions

For AmeriHealth Caritas Louisiana Providers

May 2025

AmeriHealth Caritas Louisiana

Claim Filing Instructions

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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** for correction and re-submission.

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

Claims filed are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification of member eligibility for services under AmeriHealth Caritas Louisiana during the time period in which services were provided.
- Verification for electronic claims against 837 edits at Optum/Change Healthcare or Availity.
- 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 all diagnosis and procedure codes are valid for the date 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 resource and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to the Plan.
- All 837 claims should be compliant with SNIP level 4 standards ,with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN and Location Numbers).

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 must be resubmitted as a new claim with the valid and/or required missing data elements within 365 calendar days from the date of service.

Denied claims are registered in the claim processing system but do not meet requirements for payment under AmeriHealth Caritas Louisiana guidelines.

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

Set the claim frequency code correctly and send the original claim number. These are required elements and the claim will be rejected if not coded correctly.

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 **only** to the following address in London, Kentucky. Do **not** send claims to the Baton Rouge office. Claims are **not** processed at the Baton Rouge office.

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

If you choose to send certified mail, it is recommended that you use USPS certified tracking for packages, because typically packages are not deliverable to a Post Office Box via UPS or FedEx.

If you are submitting medical records on a Compact Disc (CD), the following requirements apply:

- The CDs with medical records cannot exceed 999 pages.
- If the document exceeds 999, the document needs to be split into multiple CDs that do not exceed 999 pages.

For those interested in electronic claim filing, contact your EDI software vendor or one of the following clearinghouses:

- **Optum/Change Healthcare's Provider Support Line,** available via online chat or by calling **1-800-527-8133, option 2,** Monday - Friday, 7am to 5:30pm CT.
- **Availity Client Services at 1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 7 AM to 7 PM CT.

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

The Plan encourages all providers to submit claims electronically. Providers may submit electronic claims via Optum/Change Healthcare or Availity clearinghouses. Throughout this document we will use "clearinghouse or clearinghouse" to mean either Optum/Change Healthcare or Availity.

Claim Filing Deadlines

Original invoices must be submitted to the Plan within 365 calendar days from the date services were rendered or compensable items were provided. (See exception below for retro enrollees and Medicare primary enrollees.)

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

Claims with Explanation of Benefits (EOBs) from primary insurers (excluding Medicare) must also be submitted within 365 days of the date of service.

An enrollee may be retroactively enrolled up to 12 months prior to the enrollee's linkage add date. Providers have up to 365 calendar days from the date of service or 180 calendar days from the enrollee's linkage add date, whichever is later, to submit claims for date of service during the retrospective enrollment period.

When Medicare is primary, claims must be filed within 180 calendar days from Medicare's EOB of payment or denial.

Refunds for Claims Overpayments or Errors

It is the provider's responsibility to return any Medicaid Program funds that were improperly paid. If a provider identifies improper payment or overpayment of claims from AmeriHealth Caritas Louisiana, the improperly paid or overpaid funds must be returned within 60 days from the date of discovery of the overpayment.

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.

Request for Claims Adjustments

Request for claims adjustments may be submitted electronically or on paper with the proper identification on the claim form. See instructions under CMS 1500 Claim Form Field & EDI Requirements and UB-04 Claim Form & EDI Requirements sections in this manual.

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

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

Provider Complaints, Claim Disputes, Member Appeals (or Provider Acting on Behalf of Member) and Grievances

Please refer to the AmeriHealth Caritas Louisiana **Provider Handbook** for complete instructions on submitting provider complaints, claim disputes, member appeals (or provider acting on behalf of member) and grievances..

Recovery Related Claim Resubmissions

If a recovery letter is received and a corrected claim needs to be resubmitted to resolve the recovery, providers have 45 days from the date of the recovery letter to send in the corrected claim.

If the corrected claim is not received within the 45 day deadline the claim will be denied for timely filing.

Clean Claim Interest Payment and Claims Reprocessed Due to Payment Errors

If AmeriHealth Caritas Louisiana, the Louisiana Department of Health (LDH) or subcontractors or providers discover errors made by AmeriHealth Caritas Louisiana when a claim was adjudicated, corrections are made and reprocessed within fifteen (15) calendar days of discovery or notification, or if circumstances exist that prevent from meeting this time frame, by a specified date subject to LDH written approval.

AmeriHealth Caritas Louisiana pays providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) calendar day clean claims processing deadline.

Interest owed to the provider shall be paid on the same date that the claim is adjudicated and by either the fifteen (15) calendar day claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later.

All impacted claims for all providers are automatically recycled and the providers are not required to resubmit the impacted claims.

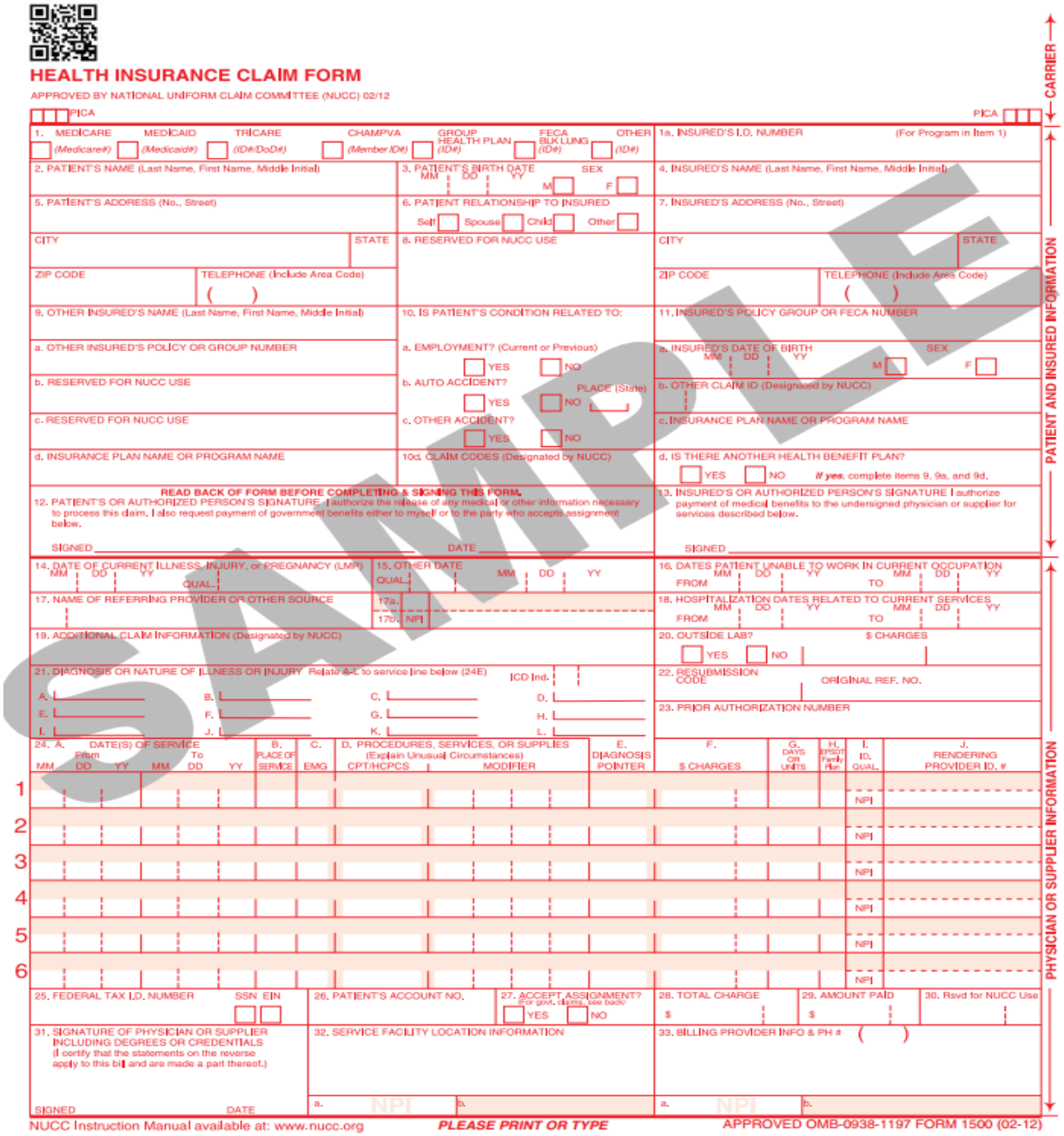
Weekly Check Cycles

Two (2) provider payment cycles are run per week, (Mondays and Wednesdays). On occasion, there may be one check run for the week due to an AmeriHealth Caritas Louisiana recognized holiday.

Claims System Updates

The claims adjudication system is updated within 30 days of receiving new fee schedules from the Louisiana Department of Health and claims are recycled within 15 days after the system updates.

CMS 1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For govt. claims, see back YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

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.

CMS 1500 Claim Form Field & EDI Requirements

The CMS 1500 claim form must be completed for all services that have requirements on the CMS 1500 claim form. **Claims must be submitted within the required filing deadline of 365 days from the date of service** (see **exceptions** under **Claim Filing Deadlines** section in this manual). Claim data requirements apply to all claim submissions, regardless of the method of submission electronic or paper.

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
N/A	**Carrier Block**			2010BB	NM103 N301 N302 N401 N402 N403
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	**R**	2000B	SBR09
1a	**Insured's I.D. Number** **(Enter the Member ID Number)**	Enter the Member ID number as it appears on the AmeriHealth Caritas Louisiana Member ID card. For electronic submissions, this ID must be less than 17 alphanumeric characters.	**R**	2010BA	NM109
2	**Patient's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's AmeriHealth Caritas Louisiana Member ID card or enter the newborn's name when the patient is a newborn.	**R**	2010CA or 2010BA	NM103 NM104 NM105 NM107
3	**Patient's Birth Date/Sex**	MMDDYY / M or F Enter the patient's birth date and select the appropriate gender.	**R**	2010CA or 2010BA	DMG02 DMG03

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
4	**Insured's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the AmeriHealth Caritas Louisiana Member ID card, or enter the newborn's name when the patient is a newborn.	**R**	2010BA	NM103 NM104 NM105 NM107
5	**Patient's Address (Number, Street, City, State, Zip) Telephone (with Area Code)**	Enter the patient's complete address and telephone number. (Do not punctuate the address or telephone number.)	**R**	2010CA	N301 N401 N402 N403 N404
6	**Patient Relationship To Insured**	Always indicate self unless covered by someone else's insurance.	**R**	2000B 2000C	SBR02 PAT01
7	**Insured's Address (Number, Street, City, State, Zip Code) Telephone (with Area Code)**	If same as the patient, enter "Same". Otherwise, enter insured's information.	**R**	2010BA	N301 N302 N401 N402 N403
8	**Patient Status**	Not used.	**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 the patient is covered by another insurance plan. Enter the complete name of the insured.	**C**	2330A	 NM103 NM104 NM105 NM107

CMS 1500 Claim Form & EDI Requirements					
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**
9a	**Other Insured's Policy Or Group #**	**Required** if # 9 is completed.	**C**	2320	SBR03
9b	**Reserved for NUCC use**	To be determined.	**Not Required**	N/A	N/A
9c	**Reserved for NUCC use**	To be determined.	**Not Required**	N/A	N/A
9d	**Insurance Plan Name Or Program Name**	**Required** if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other Medical insurance is available or if 9a is completed.	**C**	2320	SBR04
10 a,b,c	**Is Patient's Condition Related to:**	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident (Including Place/State) c) Other Accident	**C**	2300	CLM11
10d	**Claim Codes (Designated by NUCC)**	Enter new Condition Codes as appropriate. Available 2-digit Condition Codes include eight codes for abortion services and four codes for transport. Please refer to NUCC for the complete list of codes. Examples include: • AD – Abortion performed due to	**C**	2300	K3 use K3 Segment with HIPAA Compliant codes

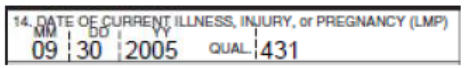
CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
		life endangering physical condition caused by, arising from or exacerbated by the pregnancy itself. • AK – Air ambulance required.			
11	**Insured's Policy Group or Federal Employee's Compensation Act (FECA) #**	Required when other insurance is available. Complete if more than one other Medical insurance is available or if "yes" to 10 a, b, c. Enter the policy group or FECA number.	**C**	2000B	SBR03
11a	**Insured's Birth Date / Sex**	Same as # 3. Required if 11 is completed.	**C**	2010BA	DMG02 DMG03
11b	**Other Claim ID**	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: • Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line; identifier to the right of the vertical, dotted line.	**C**	**2010BA**	**REF01** **REF02**

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
11c	**Insurance Plan Name or Program Name**	Enter name of the health plan. **Required** if 11 is completed.	**C**	2000B	SBR04
11d	**Is There Another Health Benefit Plan?**	Indicate Yes or No by checking the box. If Yes, complete # 9 a-d.	**R**	2320	
12	**Patient's or Authorized Person's Signature**	On the 837, the following values are addressed as follows at the clearinghouses: "A", "Y", "M", "O" or "R", then change to "Y", else send "I" (for "N" or "I").	**R**	2300	CLM09
13	**Insured's or Authorized Person's Signature**		**C**	2300	CLM08
14	**Date of Current Illness Injury, Pregnancy (LMP)**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include: • 431 – Onset of Current Symptoms or Illness • 439 – Accident Date • 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy.	**C**	2300	DTP01 DTP03

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
		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**	2300	DTP01 DTP03
16	**Dates Patient Unable to Work in Current**		**C**	2300	DTP03

CMS 1500 Claim Form & EDI Requirements					
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**
	Occupation				
17	**Name of Referring Physician or Other Source**	**Required** if a provider other than the member's primary care physician rendered invoiced services. Enter applicable 2-digit qualifier to left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Qualifiers include: • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider Example:  Example of a service requiring Referring Provider (DN qualifier) • If the member was referred to the billing provider for chiropractic	**C**	2310A (Referring) 2310D (Supervising) 2420 (Ordering)	NM101 NM103 NM104 NM105 NM107

CMS 1500 Claim Form & EDI Requirements					
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**
		services. Examples of services requiring Ordering Provider (DK qualifier) • Services performed by an independent laboratory. • Diagnostic testing. • Services performed by a pediatric day health care clinic. • Services are for DME.			
17a	**Other ID Number of Referring Physician** **(AmeriHealth Caritas Louisiana Provider ID#)**	Enter the AmeriHealth Caritas Louisiana Provider ID 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, please refer to the NUCC guidelines for the appropriate qualifier. **Required if #17 is completed.**	**C**	2310A (Referring) 2010D (Supervising) 2420E (Ordering)	REF01 REF02
17b	**NPI**	Enter the NPI number of the referring provider, ordering provider or other source. **Required if #17 is completed**.	**C**	2310D	NM109

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
18	**Hospitalization Dates Related to Current Services**	**Required** when place of service is in-patient. **MMDDYY** (indicate **from** and **to** date).	**C**	2300	DTP03
19	**Additional Claim Information (Designated by NUCC)**	Enter additional claim information with identifying qualifiers as appropriate. For multiple items, enter three blank spaces before entering the next qualifier and data combination. Claim Attachment Report Type codes in 837P defines the following qualifiers 03 - Itemized Bill M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice 07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet When submitting 275 transactions (claim attachments) use:	**Not Required** **R** **R**	2300 2300 2400	NTE PWK PWK01 **NOTE**: Claim Attachment Report Type codes in 837P SV101-7

CMS 1500 Claim Form & EDI Requirements

<table>
<tr><th>Field #</th><th>Field Description</th><th>Instructions and Comments</th><th>Required or Conditional*</th><th>Loop ID</th><th>Segment</th></tr>
<tr><td></td><td></td><td>Payer name: AmeriHealth Caritas Louisiana

Payor ID: 23757

Enter applicable Evidence Based Practice Codes (EB01-EB08)

<table>
<tr><td>EB01</td><td>H0036 with modifier HE</td></tr>
<tr><td>EB02</td><td>90837,
90834,
90832,
90847,
90846</td></tr>
<tr><td>EB03</td><td>90837,
90834,
90832,
90847,
90846</td></tr>
<tr><td>EB04</td><td>90837,
90834,</td></tr>
</table>
</td><td></td><td></td><td></td></tr>
</table>

CMS 1500 Claim Form & EDI Requirements						
Field #	**Field Description**	**Instructions and Comments**		**Required or Conditional***	**Loop ID**	**Segment**
			90832, 90847, 90846			
		EB05	90837, 90834, 90832, 90847, 90846			
		EB06	90837, 90834, 90832, 90847, 90846			
		EB07	90837, 90834, 90832, 90847, 90846			

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments		Required or Conditional*	Loop ID	Segment
		EB08	90837, 90834, 90832, 90847, 90846			
20	**Outside Lab**	**Conditional**		**C**	2400	PS102
21	**Diagnosis or Nature of Illness or Injury. (Relate To 24E)**	Enter the applicable ICD indicator to identify the version of ICD coding being reported between the vertical dotted lines in the upper right-hand portion of the field, as in the example below. 0 = ICD-10-CM  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.		**R**	2300	HIXX-02 Where XX = 01,02,03,04,05,06,07, 08,09,10,11,12

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
		Note: Claims with invalid diagnosis codes will be denied for payment. ICD-10 external cause of injury diagnosis codes V, W, X and Y are not acceptable as a primary diagnosis.			
22	**Resubmission Code and/or Original Ref. No.**	This field is required for resubmissions or adjustments/corrected claims. For resubmissions or adjustments, enter the appropriate bill frequency code (7 or 8 – see below) in the Submission Code section, and the Claim ID# of the original claim in the Original Ref. No. section of this field. • 7 – Replacement of Prior Claim • 8 – Void/cancel of Prior Claim	**C**	2300 2300	CLM05-3 REF02 Where REF01 = F8
23	**CLIA Certificate ID**	Enter the CLIA number relevant to the location the provider is performing on site lab testing when applicable. The number must include the "X4" qualifier, the two-digit state code, followed by the letter "D" and then the assigned CLIA number. EXAMPLE: of valid CLIA number formatting: X419DXXXXXXX	**R**	2300	
24A	**Date(s) of Service** **See page** "Special Instructions and	"From" date: MMDDYY. If the service was performed on one day there is no need to complete the "to" date. See "Special Instructions and Examples for CMS 1500" for additional instructions on completing	**R**	2400	DTP03

CMS 1500 Claim Form & EDI Requirements					
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**
	Examples for CMS 1500" **for supplemental guidance on the shaded portions of fields 24 A – J.**	the shaded portion of field 24.			
24B	**Place of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable. **99 (PDHC)** **NOTE:** Effective **November 6, 2024** place of service (**POS**) code **27** may be used when providing services in a non-permanent location, such as a street or public area that is not already described by another POS where preventive, screening, diagnostic and treatment services are provided by health professionals using the following procedure codes: 99202, 99203, 99204, 99211, 99212, 99213, 99214, 99381, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99405, 99406, 99407, 99408, G0438, and G0439	**R**	2300 2400	CLM05-1 SV105
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**	2400	SV109

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
24D	**Procedures, Services or Supplies CPT/HCPCS/ Modifier**	Enter the CPT or HCPCS code(s) and modifier (if applicable). Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service.	**R**	2400	SV101 (2-6)
24E	**Diagnosis Pointer**	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (A-L). Note: AmeriHealth Caritas Louisiana can accept up to eight (8) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	**R**	2400	SV107(1-4)
24F	**Charges**	**Enter charges. A value must be entered. Enter zero ($0.00) or actual charged amount. (This includes capitated services.)**	**R**	2400	SV102
24G	**Days or Units**	Enter quantity. Value entered must be greater than zero. Field allows up to 3 digits.	**R**	2400	SV104
24H	**Child Health Check (EPSDT) Services**	Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	**C**	2300 2400	CRC SV111 SV112
24I	**ID Qualifier**	If using taxonomy code in field 24J, enter the qualifier "ZZ". If the Other ID number is the AmeriHealth	**C**	2310B	REF01 NM108

CMS 1500 Claim Form & EDI Requirements					
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**
		Caritas Louisiana ID number, enter G2. If the Other ID number is another unique identifier, please refer to the NUCC guidelines for the appropriate qualifier.			
24J	**Rendering Provider ID NPI in the bottom (unshaded) portion. Enter the AmeriHealth Caritas Louisiana Provider ID number in the top (shaded) portion.**	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. (Except on a claim for Ambulance, Ambulatory Surgical Center (ASC), BH facility, DME, Home Health, Independent Lab, Independent Radiology, Substance Abuse Center and VOA bundles).**	**R**	2310B	REF02 NM109
25	**Federal Tax ID Number SSN/EIN**	Physician or Supplier's Federal Tax ID number.	**R**	2010AA	REF01 REF02
26	**Patient's Account No.**	Enter the patient's account number assigned by the provider	**R**	2300	CLM01
27	**Accept Assignment**	Yes or No must be checked.	**R**	2300	CLM07
28	**Total Charge**	Enter the total of all charges listed on the claim.	**R**	2300	CLM02

CMS 1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	**C**	2300 2320	AMT02 AMT02
30	**Reserved for NUCC Use**	To be determined.	**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. (**Except for Behavioral Health Claims and DME).**	**R**	2300	CLM06
32	**Name and Address of Facility Where Services Were Rendered**	Enter Name, address, and ZIP Code (ZIP+4) of the service location. Required when it is a physician performing on site lab testing. Ambulance providers are required to enter the following: The complete address of origin of services, the time of departure from origin (including a.m. or p.m.), the complete address of destination, and the time of arrival at destination (including a.m. or p.m.) P O Boxes are not acceptable here.	**C**	2310C	NM103 N301 N401 N402 N403

CMS 1500 Claim Form & EDI Requirements

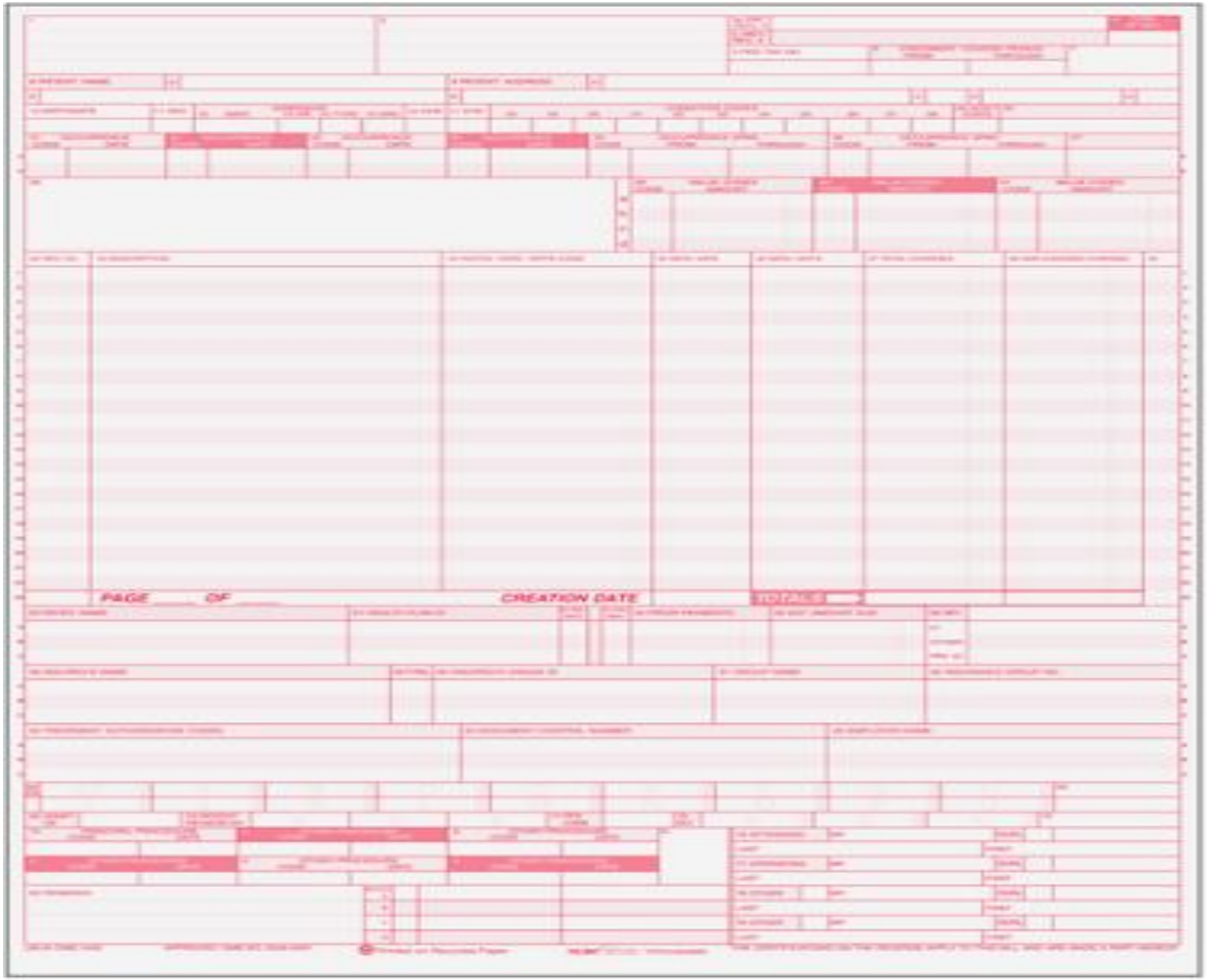
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
32a.	**NPI number**	**Required** unless servicing provider is an atypical provider and is not required to have an NPI number.	**R**	2310C	NM109
32b.	**Other ID#** **(AmeriHealth Caritas Louisiana issued Provider Identification Number)**	Enter the AmeriHealth Caritas Louisiana Provider ID # (strongly recommended). **Required** when the servicing 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.	**C** **Recommended**	2310C	REF01 REF02
33	**Billing Provider Info & Ph #**	**Required** – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. P.O. Boxes are accepted.	**R**	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04
33a.	**NPI Number**	**Required** unless servicing provider is an atypical provider and is not required to have an NPI number.	**R**	2010AA	NN109

CMS 1500 Claim Form & EDI Requirements					
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**
33b.	**Other ID#** **(AmeriHealth Caritas Louisiana issued Provider Identification Number)**	Enter the AmeriHealth Caritas Louisiana Provider ID # (strongly recommended).	**C** **Recommended**	2000A 2010AA	PRV03 REF02 where REF01=G2

Disclaimer: The claim form (s) 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. Please refer to the NUCC 1500 Claim Form Reference Instruction Manual or NUBC Official UB-04 Data Specifications Manual for additional information.**

UB-04 Claim Form



UB-04 Claim Form & EDI Requirements

The UB-04 claim form must be completed for all services requiring submission on the UB-04 claim form. **Claims must be submitted within the required filing deadline of 365 days from the date of service** (see **exceptions** under **Claim Filing Deadlines** section in this manual). Claim data requirements apply to all claim submissions, regardless of the method of submission electronic or paper.

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
1	**Unlabeled Field**	Service/billing provider name, address and telephone number should be entered in this field. Left justified Line a: Enter the complete provider name. Line b: Enter the complete street information. **No P.O. Boxes**. Line c: City, State, and Zip Code (Zip Codes should include Zip + 4 for a total of 9 digits). Line d: Enter the area code and telephone number.	**R**	**R**	2010AA	NM1/85 N3 N4

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
2	**Unlabeled Field**	**Enter remit address** Billing provider's designated pay-to address. (Zip Codes should include Zip + 4 for a total of 9 digits). Enter the AmeriHealth Caritas Louisiana Facility Provider ID number. Left justified.	**R**	**R**	2010AB	NM1/87 N3 N4
3a	**Patient Control No.**	Provider's patient account/control number.	**R**	**R**	2300	CLM
3b	**Medical Record Number**	The number assigned to the patient's medical record by the provider.	**R**	**R**	2300	REF02 where REF01 = EA
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	**R**	**R**	2300	CLM05 1/2/3

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		claims. Second position indicates type of facility. 1= Hospital Third position indicates type of care. 1= Inpatient Medicaid and/or Medicare Part A or Parts A & B 2= Inpatient Medicaid and Medicare Part B only 3= Outpatient or Ambulatory Surgical Center Fourth position indicates billing sequence. 0 = Non-Payment claim 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim				

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		7 = Replacement of prior claim 8 = Void of prior claim On Part A Exhausted claims and Part B Only claims, 121 must be entered as the Type of Bill (TOB)				
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	**R**	**R**	2010AA	REF02 Where REF01=EI
6	**Statement Covers Period From/Through**	Enter dates for the full ranges of services being invoiced. MMDDYY	**R**	**R**	2300	DTP03 where DTP01 = 434
7	**Unlabeled Field**	No entry required				
8a	**Patient Identifier**	Patient AmeriHealth Caritas Louisiana ID is conditional if number is different from field 60.	**C**	**C**	2010BA	NM109 where NM101 = IL NM109 where

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
					2010CA	NM101 = QC
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	**R**	**R**	2010BA 2010CA	NM103, NM104, NM107 where NM101=IL NM103,NM104, NM107 where NM101 = QC

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		(no space). Suffix: A space should separate a last name and suffix.				
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**	2010BA 2010CA	N301, N302 N401, 02, 03, 04 N301, N302 N401, 02, 03, 04
10	**Patient Birth Date**	The date of birth of the patient. MMDDYYYY	**R**	**R**	2010BA 2010CA	DMG02 DMG02
11	**Patient Sex**	The sex of the patient recorded at admission, outpatient service, or start of care.	**R**	**R**	2010BA 2010CA	DMG03 DMG03

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
12	**Admission Date**	The start date for this episode of care. For inpatient services, this is the date of admission.	**R**	**R**	2300	DTP03 where DTP01=435
13	**Admission Hour**	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Code Time 00 = 12:00 - 12:59 midnight 01 = 01:00 - 01:59 A.M. 02 = 02:00 - 02:59 03 = 03:00 - 03:59 04 = 04:00 - 04:59 05 = 05:00 - 05:59 06 = 06:00 - 06:59 07 = 07:00 - 07:59 08 = 08:00 - 08:59	**R** **For bill types other than 21X.**	**Not Required.**	2300	DTP03 where DTP01=435

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		09 = 09:00 - 09:59 10 = 10:00 - 10:59 11 = 11:00 - 11:59 12 = 12:00 - 12:59 noon 13 = 01:00 - 01:59 P.M. 14 = 02:00 - 02:59 15 = 03:00 - 03:59 16 = 04:00 - 04:59 17 = 05:00 - 05:59 18 = 06:00 - 06:59 19 = 07:00 - 07:59 20 = 08:00 - 08:59 21 = 09:00 - 09:59 22 = 10:00 - 10:59				

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		23 = 11:00 - 11:59				
14	**Admission Type**	A code indicating the priority type of this admission/visit. Codes 1=Emergency 2=Urgent 3=Elective 4=Newborn 5=Trauma	**R**	**R**	2300	CL101

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
15	**Source of Referral for Admission**	A code indicating the source (or point of origin) of the referral for this admission or visit. Please use the applicable code from NUBC Official UB-04 Data Specifications Manual.	**R**	**R**	2300	CL102
16	**Discharge Hour**	Code indicating the discharge hour of the patient from inpatient care. Enter the two-digit code which corresponds to the hour the patient was discharged. See field 13 for specific codes.	**R**	**Not Required**	2300	DTP/096/03
17	**Patient Discharge Hour**	A code indicating the disposition or discharge status of the patient at the end of the service for the period covered on this bill,	**R**	**R**	2300	CL103

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		as reported in field 6. Please refer to the NUBC Official UB-04 Data Specifications Manual for a list of status codes.				
18 - 28	**Condition Codes**	A code used to identify conditions or events relating to the bill that may affect processing. Please refer to the NUBC Official UB-04 Data Specifications Manual for condition codes and descriptions to complete fields 18 – 28.	**C**	**C**	2300	HIXX-2
29	**Accident State**	The accident state field contains the two-digit state abbreviation where the accident occurred. **Required when applicable.**	**C**	**C**	2300	REF02
30	**Unlabeled Field**	**Leave Blank.**				
31a,b – 34a,b	**Occurrence Codes and Dates**	Enter the appropriate occurrence code from the NUBC Official UB-04 Data	**C**	**C**	2300	

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		Specifications Manual and date. **Required** when applicable.				HIXX-1 = BH
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. Please refer to the NUBC Official UB-04 Data Specifications Manual for a list of occurrence span codes.	**C**	**C**	2300	
37a,b	**Unlabeled Field**	**Required only for EPSDT claims.** Enter the applicable 2-character EPSDT Referral Code from below for referrals made or needed as a result of the screen. YD – Dental *(Required for Age 3 and Above)	C	C	2300	K3

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		YO – Other YV – Vision YH – Hearing YB – Behavioral YM – Medical				
38	**Responsible Party Name and Address**	**Enter 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. If more than one value code applies, list in alphanumeric order. **Required** when applicable.	**C**	**C**	2300	HIXX-2 HIXX-5

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		Note: If value code is populated then value amount must also be populated and vice versa. 02 = Hospital has no semi-private rooms. Entering the code requires $0.00 amount to be shown. 06 = Medicare blood deductible 08 = Medicare lifetime reserve first CY 09 = Medicare coinsurance first CY 10 = Medicare lifetime reserve second year 11 = Coinsurance amount second year 12 = Working aged recipient/spouse with employer group health plan				

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		13 = ESRD (end stage renal disease) recipient in the 12-month coordination period with an employer's group health plan 14 = Automobile, no fault or any liability insurance 15 = Worker's compensation including Black Lung 16 = VA, PHS, or other federal agency 30 = Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission. 37 = Pints blood furnished 38 = Blood not replaced - deductible is patient's responsibility				

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		39 = Blood pints replaced *80 = Covered days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims) Hospice providers should enter the value code 61 in the "code" section of the field; and then the appropriate Metropolitan Statistical Area (MSA) code in the "Dollar" portion and the "00" in the "Cents" field for each service line billed on the UB-04 even if it is multiple occurrences of the				

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		same service in the same month. A1,B1,C1 = Deductible A2,B2,C2 = Co-insurance ***Enter the appropriate value code in the code portion of the field and the number of days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.** **The dollars/cents data must be entered accurately to prevent claim denials.**				
42	**Revenue Code**	Codes that identify specific accommodation, ancillary service or unique billing	**R**	**R**	2400	SV201

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		calculations or arrangements. On the last line, enter 0001 for the total. Please refer to the Uniform Billing Manual for a list of revenue codes. Hospice providers billing revenue code **655** for **Respite Care** may only bill with this code for the first 5 days per admission. After the 5 days, then it should be billed with revenue code 651 route home care. Hospice providers billing revenue code 656 for **General Inpatient Care** may bill with no restriction on days. See the **Hospice** section of this manual for more claim filing details.				
43	**Revenue Description**	Enter the narrative description of the	**R**	**R**	N/A	N/A

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		corresponding Revenue Code in field 42. Claims reporting Physician Administered Drugs must include the NDC information in field 43. Please refer to "**Special Instructions and Examples for CMS 1500, UB-04 and EDI Claims Submissions"** in this document for detailed instructions on how to report NDC information in this field.				
44	**HCPCS/Accommodation Rates/HIPPS Code**	1. The 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	**R**	**R**	2400	SV202-2

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Enter the applicable rate, HCPCS or HIPPS code and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all Outpatient Claims. **Note**: NDC numbers are required for all administered or supplied drugs. Enterals do not require an NDC; however, metabolic formula does require an NDC. Enter the corresponding HCPCS Code for the NDC reported in field 43.				

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
45	**Service Date**	Report line item dates of service for each revenue code or HCPCS code.	**R**	**R**	2400	03DTP03 where DTP01=472
46	**Service 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. **Note**: For drugs, service units must be consistent with the NDC code and its unit of measure. NDC unit of measure must be a valid HIPAA UOM code or claim should be rejected.	**R**	**R**	2400	SV205
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	**R**	**R**	2300	SV203

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		covers period. Total charges include both covered and non-covered charges. Report grand total of submitted charges at the bottom of this field to be associated with revenue code 001. Value entered must be greater than zero ($0.00).				
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. If there is more than one other private payer, lump all amounts together in field 48 and attach each company's	**C**	**C**	2400	SV207

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		EOB or RA.				
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.	**C**	**C**	2330B	NM103 where NM101=PR
51	**Health Plan ID**	The number used by the health plan to identify itself. AmeriHealth Caritas Louisiana's Payer ID is #27357.	**R**	**R**	2330B	NM109 where NM101=PR
52	**Release of Information**	Release of information certification indicator. This field is required on paper and electronic invoices. Line A refers to the primary payer;	**R**	**R**	2300	CLM09

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		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".				
53	**Assignment of Benefits**	Assignment of benefits certification indicator is required. The A, B, C indicators refer to the information in field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	**R**	**R**	2300	CLM08

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
54	**Prior Payments**	The A, B, C indicators refer to the information in field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary. On Part A Exhausted Claims when Part B is billed the Part B billed amount is required in this field. **(See field 4 for correct Type of Bill)**	**C** **R**	**C**	2320	AMT02 where AMT01=D
55	**Estimated Amount Due**	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage). The amount up to two decimal places.	**C**	**C**	2300	AMT02 where AMT01 =EAF

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
56	**National Provider Identifier**	The unique NPI identification number assigned to the provider submitting the bill.	**R**	**R**	2010AA	NM109 where NM101 = 85
57 A,B,C	**Other Provider ID**	It is strongly recommended to enter the provider identification number assigned by AmeriHealth Caritas Louisiana. The UB-04 does not use a qualifier to specify the type of Other Provider ID. Required for providers not submitting NPI in field 56. Use this field to report other provider IDs assigned by the health plans listed in field 50 A, B and C.	**C**	**C**	2010AA 2010BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 = 2U
58	**Insured's Name**	Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the	**R**	**R**	2010BA 2330A	NM103,NM104, NM105 where NM101 = IL NM103,NM104, NM105 where

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		insured is indicated here.				NM101 = IL
59	**Patient Relationship**	Enter the applicable code for the patient's relationship to insured. Please refer to the NUBC Official UB-04 Data Specifications Manual for the list of accepted Patient Relationship Codes.	**R**	**R**	2000B	SBR02
60	**Insured's Unique ID** **AmeriHealth Caritas Louisiana Member ID Number**	Enter the patient's Member ID on the appropriate line, exactly as it appears on the patient's AmeriHealth Caritas Louisiana ID card on line B or C. If insurance coverage other than Medicaid applies, enter the insured's ID number as assigned by the other carrier or carriers in 60A or 60B if	**R**	**R**	2010BA	NM109 where NM101= IL REF02 where REF01 = SY

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		more than one and the AmeriHealth Caritas Louisiana ID would be listed last in either B or C. Line A refers to the primary payer; Line B, secondary; and Line C, tertiary.				
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; Line B, secondary; and Line C, tertiary.	**C**	**C**	2000B	SBR04

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
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; Line B, secondary; and Line C, tertiary.	**C**	**C**	2000B	SBR03
63	**Treatment Authorization Codes**	Enter the AmeriHealth Caritas Louisiana prior authorization number. Line A refers to the primary payer; Line B, secondary; and Line C, tertiary. **Field 63A is required if a prior authorization was**	**C**	**C**	2300	REF02 where REF01 = G1

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		required.				
64	**Document Control Number**	The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. **Note: This field is required for resubmitted claims and must contain the original claim ID.**	**C**	**C**	2300	REF02 where REF01 = F8
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.	**C**	**C**	2320	SBR04

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. A value of 10 indicates ICD-10. **Note:** Claims with invalid codes will be denied for payment.	**Not Required**	**Not Required**	2300	Determined by the qualifier submitted on the claim
67	**Principle Diagnosis Code and Present on Admission (POA) Indicator**	The appropriate ICD codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the use of hospital services that exists at the time of services or develops subsequently to the service that has an effect on the length of stay. • **Y=Present at the time of inpatient admission** • **N=Not present at the time of inpatient admission**	**R**	**R**	2300	HIXX-2 HIXX-9 Where HI01-1 = BK or ABK

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		• **U=Documentation is insufficient to determine if condition is present on admission** • **W=Provider is unable to clinically determine whether condition was present on admission or not**				
67 A - Q	**Other Diagnosis Codes**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	**C**	**C**	2300	HIXX-2 HIXX-9 Where HI01-1 = BF or ABF
68	**Unlabeled Field**					

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
69	**Admitting Diagnosis**	The appropriate ICD code describing the patient's diagnosis at the time of admission as stated by the physician.	**R**	**R**	2300	HI02-2
70	**Patient Reason Diagnosis**	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Up to three ICD codes may be entered in fields A, B and C.	**C**	**R**	2300	HIXX-2
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	**C**	**C**	2300	HI01-2 Where HI01-1 = DR

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		to 4 digits.				
72a-c	**External Cause of Injury (ECI) Code**	ICD-10 diagnosis codes beginning with V, W, X, and Y are not acceptable in the primary or first field and/or the admitting diagnosis.	**C**	**C**	2300	HIXX-2
73	**Unlabeled Field**	No entry required.				
74	**Principal Procedure Code and Date**	The appropriate ICD code that identifies the principal procedure performed at the claim level during the period covered by this bill and the corresponding date. **Inpatient facility** – Surgical procedure code is required if the operating room was used. **Outpatient Facility -** ICD code is required when a surgical procedure is performed.	**C** **R**	**C** **R**	2300	HI01-2 HI01-4 Where HI01-1 = BR or BBR

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
74a-e	**Other Procedure Codes and Dates**	The appropriate ICD code(s) identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. **Inpatient facility** – Surgical procedure code is required if the operating room was used. **Outpatient facility -** ICD code is required when a surgical procedure is performed.	**C** **R**	**C** **R**	2300	HIXX-2 Where HI01-1 = BQ or BBQ
75	**Unlabeled Field**	No entry required				
76	**Attending NPI and Qualifier**	**Enter the NPI number of the attending physician** who has primary responsibility for the patient's medical care or treatment in the upper line, and their name in the lower	**R**	**R**	2310A 2310A 2310A	NM109 where NM101 = 71 REF02 NM103 where

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		line, last name first. **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** 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.			2301A	NM101 = 71 NM104 where NM101 = 71
77	**Operating – NPI and Qualifier**	**Enter the NPI number** of the physician who performed surgery on the patient in the upper line, and	**C**	**C**	2310B	NM109 where NM101 = 72 NM103 where

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		their name in the lower line, last name first. If the operating physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the attending physician. **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**	**R**	**R**	2310B 2310B 2310b	NM101 = 72 NM104 where NM101 = 72 REF02
78 – 79	**Other NPI and Qualifier**	Enter the NPI number of any another attending physician, other than the primary attending physician, who has responsibility for the patient's medical care or treatment in the upper line,	**R**	**R**	2310C	NM109 where NM101 = ZZ NM103 where

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		and their name in the lower line, last name first. **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** If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#.			2310C 2310C 2310C	NM101 = ZZ NM104 where NM101 = ZZ REF02
80	**Remarks Field**	Claim Attachment Report Type codes in 837I defines the following qualifiers 03 - Itemized Bill	**R**	**R**	2300	PWK01 **NOTE:** Claim Attachment Report Type codes in 837I

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA) 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice 07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval)				

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
		EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet When submitting 275 transactions (claim attachments) use: Payer name: AmeriHealth Caritas Louisiana Payor ID: 23757				

UB-04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**
81a-d	**Code Code (CC) 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**	2000A	PRV01 PRV02

Disclaimer: The claim form (s) 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. Please refer to the NUCC 1500 Claim Form Reference Instruction Manual or NUBC Official UB-04 Data Specifications Manual for additional information.**

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

CMS 1500 Paper Claims – Field 24

Important Note: All unspecified CPT or HCPCS codes require a narrative description to 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 areas of field 24:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Device Identifier of the Unique Device Identifier for supplies
- Contract rate

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

- **ZZ -** Narrative description of unspecified code (all miscellaneous fields require this section be reported)
- **N4** - National Drug Codes (NDC)
- **DI** - Device Identifier of the Unique Device Identified (UDI)
- **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 areas of field 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.

Reporting **NDC on CMS 1500**

NDC must be entered in the shaded sections of fields 24A through 24G.

To enter NDC information, begin at 24A by entering the N4 qualifier and then the 11 digit NDC:

- 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.

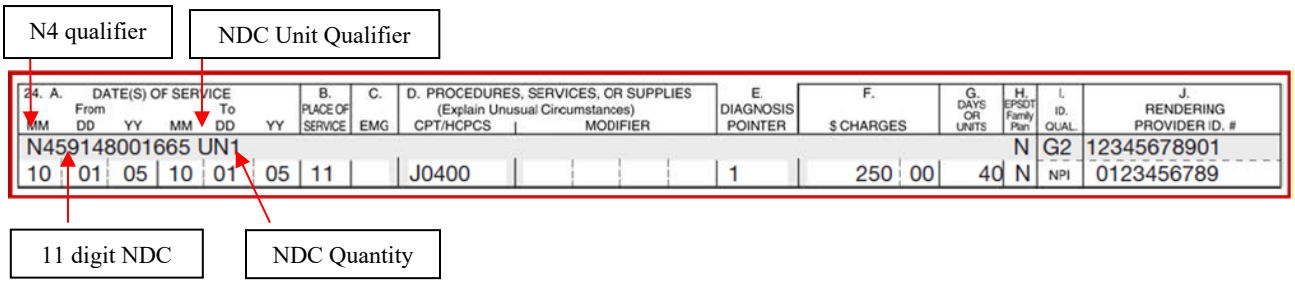
Enter a space between the 11 digit NDC number and the NDC unit qualifier with one of the following unit qualifiers:

- F2-Internationl Unit
- GR-Gram
- ME-Milligram
- ML-Milliliter
- UN-Unit

Enter the NDC quantity:

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

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



Exception: Only the 11 digit NDC number is required for DME metabolic formula (in the shaded area of 24A).

Note: NDC numbers are not required for DME enteral nutrition.

Reporting NDC on UB-04

Do not report NDC codes with revenue codes 100-249, 260-624, 640-999.

NDC must be entered in field 43-Description.

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
- ME-Milligram

- 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 UB-04 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	

NDC via EDI

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

EDI claims with NDC info should be reported in the LIN segment of Loop ID-2410. This segment is used to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1.

Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line.

Claims requiring multiple NDC's sent at claim line level should be submitted using CMS 1500 or UB-04.

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

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

Federal Tax ID on UB-04 (field 5) will come from Loop 2010AA, REF02.

Condition codes (field numbers 18 thru 29) will come from 2300 CRC01 – CRC07

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

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:

- 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

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.

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

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~

Split-Billing is required in the following circumstances.

Hospitals must split-bill claims:

- at the hospital's fiscal year end

- when the hospital changes ownership
- if the charges exceed $999, 999.99
- with more than one revenue code for a specialized per diem rate (i.e. PICU, NICU, etc.)

Hospitals have discretion to split bill claims as warranted by other situations that may arise.

Split-Billing Procedures:

- In the *Type of Bill* block (field 4) of the UB-04 claim form, the hospital must enter code 112, 113, or 114 to indicate the specific type of facility, the bill classification, and the frequency for the first part (code 2), any subsequent part (code 3) and the final part (code 4) of the split-billing interim claims.

- In the *Patient Status* block (field 17) of the UB-04 claim form, the hospital must enter a 30 to show that the member is "still a patient" unless it is the final interim bill with the discharge, then the hospital must enter 01. When split-billing, the **first** claim must **not** be coded as a discharge.

- In the *Remark**s*** section (field 80) of the UB-04 claim form, the hospital should include the part of stay for which it is split-billing. For example, the hospital should enter "Split-billing for Part 1", if it *is* billing for Part 1 or "Split-billing for Part 2", if it is billing for Part 2 or "Split-billing for Final", if it is billing the final interim claim.

- Providers submitting a hospital claim which crosses the date for the fiscal year end, must complete the claim in two parts: (1) throught the date of the fiscal year end and (2) for the first day of the new fiscal year.

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.

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

Diagnosis Code Missing 4th, 5th, 6th, or 7th Digit – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM manual for the 4th, 5th, 6th or 7th digit extensions. Look for the ✓4th, ✓5th, 6th or 7th 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-10-CM, CPT or HCPCS) is required 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. EOBs are accepted via paper or electronic format.

External Cause of Injury Codes – ICD-10 Diagnosis Codes Beginning with V, W, X, and Y are not acceptable in the primary or first field and/or the admitting diagnosis.

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 – All handwritten claims are acceptable as long as they are legible. If the claim is illegible, it will be rejected. .

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.

National Drug Code (NDC) data is missing/incomplete/invalid - The claim will be rejected if NDC data is missing, incomplete, or has an invalid unit/basis of measurement if all are required for the claim.

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 enrollee.

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

Provider Name Missing – The name of the provider performing the service must be present on the claim form and must match the service provider name and NPI/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 (**exceptions** are claims for Ambulance, ASC, BH facility, DME, Home Health, Independent Lab, Independent Radiology, Substance Abuse Center, or VOA bundle which required the **group NPI only**) 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. Please 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. Additionally, all dates of service must fall within the statement period for the claim.

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.

Other Causes of Claim Denials or Rejections:

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

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

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

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

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

If attaching an EOB, the date of service, codes and billed charges on the EOB should exactly match what is on the claim (**exceptions** would be for **RHC** and **FQHC** claims when encounter codes **T1015**, **H2020 or D0999** are billed because private insurance does not bill these codes). 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.

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

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

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.

Submit newborn's facility bill 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 LDH's Newborn Eligibility System before submitting the claim to AmeriHealth Caritas Louisiana.

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

The ***individual service provider name*** *and* ***NPI*** *number* must be indicated on all claims, including claims from outpatient clinics (**exceptions** are claims from **Ambulance**, **ASC**, **BH facility**, **DME**, **Home Health**, **Independent Lab**, **Independent Radiology**, **Substance Abuse Centers** or **VOA** bundle). Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments (**except** provider types mentioned above).

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.

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.

Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 365 calendar days from the date of service (see **exceptions** under **Claim Filing Deadlines** section in this manual).

Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 365 calendar days from the date of service (see **exceptions** under **Claim Filing Deadlines** section in this manual).

Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be updated ***immediately*** either through the NaviNet provider portal (if enrolled) or contact your Provider Network Account Executive to assist in updating the AmeriHealth Caritas Louisiana's records.

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 because 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.
- 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 and 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 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing with some exceptions for electronic (see CMS 1500 and UB-04 Claim Form & EDI Requirements sections in this manual).

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.

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

Please refer to the Claim Filing section of this manual for general claim submission guidelines.

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 clearinghouses, whether through direct submission or through a vendor, you can submit claims electronically.

Contracting with Optum/Change Healthcare and Availity

If you are a provider interested in submitting claims electronically to the Plan but do not currently have EDI capabilities, you can choose between Optum/Change Healthcare or Availity. You may contact Optum/Change Healthcare at 877-363-3666 or Availity at 800-282-4548 or you may choose a vendor who already has Optum/Change Healthcare or Availity 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 at 866-428-7419 or by email at edi@amerihealthcaritasla.com.

Read over the instructions within this booklet carefully, with special attentions to the information on exclusions, limitations, and especially, the rejections notification reports.

Contact your EDI software vendor and/or clearinghouse 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 below.

Important:

Providers using clearinghouses are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

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

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 in the CMS 1500 Claim Form & EDI Requirements section of this manual.

EDI guidance for Facility Claims can be found in the UB-04 Claim Form & EDI Requirements section of this manual.

Providers have the added functionality to submit electronic attachments (275 transactions) to support claims and 275 claims attachment report codes/instructions are also in the CMS 1500 Claim Form & EDI Requirements and the UB-04 Claim Form & EDI Requirements sections of this manual as well.

AmeriHealth Caritas Louisiana is now accepting ANSI 5010 ASC X12 275 unsolicited claim attachment transactions via Optum/Change Healthcare and Availity. Providers may submit the electronic 275 claim attachment transaction via Payer ID 27357, according to the following guidelines:

Availity: There are two ways 275 claim attachments can be submitted:

- **Batch** — You may either connect to Availity directly or submit via your EDI clearing house.
- **Portal** — Individual providers may also register at https://www.availity.com/Essentials-Portal-Registration to submit attachements

After logging in, providers registered with Availity may access the **Attachments - Training Demo** for detailed instructions on the submission process via: **Training Link [apps.availity.com]** **o**r refer to the **Availity Claims Attachement Transaction Quick Reference Guide.**

Optum/Change Healthcare: There are two ways 275 claim attachments can be submitted:

- **Batch** — You may either connect to Optum/Change Healthcare directly or submit via your EDI vendor.
- **API (via JSON)** — You may submit an attachment for a single claim.

General guidelines:

- A maximum of 10 claim attachments are allowed per submission. Each attachment cannot exceed 10 megabytes (MB), and total file size cannot exceed 100MB.
- The acceptable supported formats are pdf, tif, tiff, jpeg, jpg, png, docx, rtf, doc, and txt.
- The 275 claim attachments must be submitted prior to the 837. After successfully submitting a 275 claim attachment, an Attachment Control Number will generate. The Attachment Control Number must be submitted in the 837 transactions as follows:
  - **CMS 1500**
    - Field Number 19
    - Loop 2300
    - PWK segment

- **UB-04**
    - Field Number 80
    - Loop 2300
    - PWK01 segment

In addition to the Attachment Control Number, the following 275 claim attachment report codes must be reported in field 19 of the CMS 1500 or field number 80 of the UB -04:

Attachment Type	Claim assignment attachment report code
Itemized Bill	03
Medical Records for HAC review	M1
Single Case Agreement (SCA)/LOA	04
Advanced Beneficiary Notice (ABN)	05
Consent Form	CK
Manufacturer Suggested Retail Price /Invoice	06
Electric Breast Pump Request Form	07
CME Checklist consent forms (Child Medical Eval)	08
EOBs — for 275 attachments should only be used for non-covered or exhausted benefit letter	EB
Certification of the Decision to Terminate Pregnancy	CT
Ambulance Trip Notes/Run Sheet	AM

Clearinghouses may require additional data record requirements.

Electronic Claim Flow Description

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

Once the clearinghouse receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits. Claims not meeting the requirements are immediately rejected and returned to the sender via the clearinghouse error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or clearinghouse.

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

Claims forwarded to the Plan by the clearinghouse are immediately validated against provider and member eligibility records.

Claims that do not meet this requirement are rejected and sent back to the clearinghouse, and the clearinghouse 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 the clearinghouse or vendors must be reviewed and validated against transmittal records daily.

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

If you would like assistance in resolving submission issues reflected on either the Acceptance or Plan Claim Status reports, contact your clearinghouse.

If you need assistance in resolving submission issues identified on the 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.

The clearinghouse will produce an Acceptance report * and a Plan Claim Status Report** for *its* trading partner whether that is the EDI vendor or provider.

* An Acceptance Report verifies acceptance of each claim at the clearinghouse.

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

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.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass the clearinghouse 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 365 calendar days from the date of service (see **exceptions** under **Claim Filing Deadlines** section in this manual).

It is important that you review the Acceptance or the Plan Claim Status reports received from the clearinghouse 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

Other requirements:

- Member number must be less than 17 digits.
- Statement date must not be earlier than the date of service.
- Plan provider ID is nor required but is strongly encouraged.

Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups and apply to inpatient and outpatient claim types.

At this time, these claim records must be submitted on paper:

- Claim records requiring supportive documentation.
- Claim records for medical, administrative or claim appeals.

Claims issued on behalf of the following providers must be submitted on paper:

- Providers not transmitting through clearinghouses *or providers sending to Vendors that are not transmitting (through clearinghouses) NCPDP Claims.*
- Pharmacy (through clearinghouses).

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

If you prefer to submit **on paper**, 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

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

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

Common EDI Rejections

Invalid Electronic Claim Records – Common Rejections from a Clearinghouse:

- 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, HCPCS, 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.

**** 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, frequency code "7" for adjustment of prior claims, or frequency code "8" for a voided claim utilizing bill type in loop 2300, CLM05-03 (837P).
- Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- **Do** include the plan's claim number in order to submit your claim with the 6 or 7.
- **Do** use this indicator for claims that were previously processed (approved or denied).
- **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront).
- **Do not** submit corrected claims electronically and via paper at the same time.

For more information, please contact the AmeriHealth Caritas Louisiana EDI Hotline at 1-866-428-7419 or edi.AmeriHealth Caritas Louisiana@amerihealthcaritas.com.

Providers using our NaviNet portal (www.navinet.net) can view their corrected claims faster than available with paper submission processing.

Important: Claims *originally rejected for missing or invalid data elements* must be corrected and re-submitted within 365 calendar days from the date of service (see **exceptions** under **Claim Filing Deadlines** section in this manual). Rejected claims are not registered as received in the claim processing system. (Please refer to the definitions of rejected and denied claims under the **Procedure for Claim Submission** of the **Claim Filing** section of this manual.)

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

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

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.

NPI Processing

The Plan's provider number is determined from the NPI number using the following criteria:

- Plan ID, Tax ID and NPI number.
- If no single match is found, the service location's zip code (ZIP+4) is used.
- If no service location is included, the billing address zip code (ZIP+4) will be used.
- If no single match is found, the Taxonomy is used.
- If no single match is found, the claim is sent to the Invalid Provider queue (IPQ) for processing.
- If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim.

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.

Please check with provider services and update your NPI data as needed, by using the Provider Change Form located at: www.amerihealthcaritasla.com/provider/resources/forms/index.aspx.

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.

Important:

Provider NPI number validation is not performed at a clearinghouse.

The clearinghouse will reject claims for provider NPI only if the provider number fields are empty.

The Plan's Provider ID is recommended as follows:

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

Supplemental Specific Claim Type Instructions

Abortions

In order for reimbursement to be made for an induced abortion, providers must attach a copy of the attending physician's written certification of medical necessity or the "Office of Public Health Certification of Informed Consent-Abortion" form to their claim form.

The form is to be obtained from the Louisiana Office of Public Health via a request form [**link**] or by calling (504) 568-5330. Claims associated with an induced abortion, including those of the attending physician, hospital, assistant surgeon, and anesthesiologist must be accompanied by a copy of the attending physician's certifications, as applicable.

After Hours Care on Evenings, Weekends and Holidays

The CPT evening, weekend, and holiday codes are reimbursed in addition to the reimbursement for most outpatient evaluation and management (E&M) services when the services are rendered in settings other than hospital emergency departments during the hours of:

- Monday through Friday between 5 p.m. and 8 a.m. (when outside of regular office hours),
- Weekends (12 a.m. Saturday through midnight on Sunday), or
- State/Governor proclaimed legal holidays (12 a.m. through midnight)

Reimbursement for evening, weekend and holiday services is based on the following current CPT codes or their successors:

- 99050 (Services…at times other than regularly scheduled office hours…) or
- 99051 (Services …at regularly scheduled evening, weekend, or holiday hours…).

These procedure codes must be submitted with the code(s) for the associated evaluation and management services done on the same date of service.

Allergy Testing

CPT code 95144 (single dose vials of antigen) should be reported only if the physician providing the antigen is providing it to be injected by some other entity.

Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple dose vials. Therefore, when 95144 is billed with 95115-95117 (professional services for allergen immunotherapy), 95144 should be changed to 95165 (single or multiple antigen doses).

The reporting and supervision of preparation and provision of single or multiple antigen doses (95165) to a patient should not exceed 180 units per year. Therefore, when 95165 is billed for additional units, they will be denied.

Evaluation and Management (E/M) services are included in the global allowance for 95004-95199 (Allergy testing or allergy immunotherapy). To be separately reportable, the physician must perform a significant and separately identifiable E/M service on the same day of the procedure and be billed with modifier 25**.**

Please refer to AmeriHealth Caritas Louisiana Allergy Testing reimbursement policy for additional allergy testing billable codes.

Ambulance

Emergency ground and air ambulance services should be billed on a CMS 1500 or 837 format with the applicable place of service code below:

Service	Place of Service
Ground ambulance	41
Air Ambulance	42

When billing procedure codes A0425-A0429, A0433-A0434, and A0436 for ambulance transportation services, 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. Spaces will not be recognized as a valid modifier for those procedures requiring a modifier.

The following table identifies the valid modifiers:

Modifier	Description
DD	Trip from DX/Therapeutic Site to another DX/Therapeutic Site
DE	Trip from DX/Therapeutic Site to Residential, Domiciliary, Custodial Facility
DH	Trip from DX/Therapeutic Site to Hospital
DI	Diagnostic-Therapeutic Site/Transfer Airport Heli Pad
DJ	Diagnostic/therapeutic site other than P/H to a Non-Hospital-based Dialysis facility
DN	Trip from DX/Therapeutic Site to Skilled Nursing Facility (SNF)
DP	Trip from DX/Therapeutic Site to Physician's Office
DR	Trip from DX/Therapeutic Site to Home
DX	Trip from DX/Therapeutic Site to MD to Hospital
ED	Trip from an RDC or Nursing home to DX/Therapeutic Site
EH	Trip from an RDC or Nursing home to Hospital
EG	Trip from an RDC or Nursing home to Dialysis Facility (Hospital based)
EI	Residential Domicile Custody Facility/Transfer Airport Heli Pad
EJ	Trip from an RDC or Nursing home to Dialysis Facility (non-Hospital based)
EN	Trip from an RDC or Nursing home to SNF
EP	Trip from an RDC or Nursing home to Physician's Office
ER	Trip from an RDC or Nursing home to Physician's Office
EX	Trip from RDC to MD to Hospital
GE	Trip from HB Dialysis Facility to an RDC or Nursing Home
GG	Trip from HB Dialysis Facility to Dialysis Facility (Hospital Based)

GH	Trip from HB Dialysis Facility to Hospital
GI	HB Dialysis Facility/Transfer Airport Heli Pad
GJ	Trip from HB Dialysis Facility to Dialysis Facility (non-Hospital Based)
GN	Trip from HB Dialysis Facility to SNF
GP	Trip from HB Dialysis Facility to Physician's Office
GR	Trip from HB Dialysis Facility to Patient's Residence
GX	Trip from HB Dialysis Facility to MD to Hospital
HD	Trip from Hospital to DX/Therapeutic Site
HE	Trip from Hospital to an RDC or Nursing Home
HG	Trip from Hospital to Dialysis Facility (Hospital Based)
HH	Trip from One Hospital to Another Hospital
HI	Hospital/Transfer Airport Heli Pad
HJ	Trip from Hospital to Dialysis Facility
HN	Trip from Hospital SNF
HP	Trip from Hospital to Physician's Office
HR	Trip from Hospital to Patient's Residence
IH	Transfer Airport Heli Pad/Hospital
II	Site of Ambulance transport modes transfer to another Site of Ambulance transport modes transfer
JD	Non-Hospital-based Dialysis facility to a Diagnostic/therapeutic site other than P/H
JE	Trip from NHB Dialysis Facility to RDC or Nursing Home
JG	Trip from NHB Dialysis Facility to Dialysis Facility (Hospital Based)
JH	Trip from NHB Dialysis Facility to Hospital
JI	NHB Dialysis Facility/Transfer Airport Heli Pad
JN	Trip from NHB Dialysis Facility to SNF
JP	Trip from NHB Dialysis Facility to Physician's Office
JR	Trip from NHB Dialysis Facility to Patient's Residence
JX	Trip from NHB Dialysis Facility to MD to Hospital
ND	Trip from SNF to DX/Therapeutic Site

NE	Trip from SNF to an RDC or Nursing Home
NG	Trip from SNF to Dialysis Facility (Hospital based)
NH	Trip from SNF to Hospital
NI	Skilled Nursing Facility/Transfer Airport Heli Pad
NJ	Trip from SNF to Dialysis Facility (non-Hospital based)
NN	Trip from SNF to SNF
NP	Trip from SNF to Physician's Office
NR	Trip from SNF to Patient's Residence
NX	Trip from SNF to MD to Hospital
PD	Trip from a Physician's Office to DX/Therapeutic Site
PE	Trip from a Physician's Office to an RDC or Nursing Home
PG	Trip from a Physician's Office to Dialysis Facility (Hospital based)
PH	Trip from a Physician's Office to a Hospital
PI	Physician's Office/Transfer Airport Heli Pad
PJ	Trip from a Physician's Office to Dialysis Facility (non-Hospital based)
PN	Ambulance trip from the Physician's Office to Skilled Nursing Facility
PP	Ambulance trip from Physician to Physician's Office
PR	Trip from Physician's Office to Patient's Residence
RD	Trip from the Patient's Residence to DX/Therapeutic Site
RE	Trip from the Patient's Residence to an RDC or Nursing Home
RG	Trip from the Patient's Residence to Dialysis Facility (Hospital based)
RH	Trip from the Patient's Residence to a Hospital
RI	Residence/Transfer Airport Heli Pad
RJ	Trip from the Patient's Residence to Dialysis Facility (non-Hospital based)
RN	Trip from the Patient's Residence to Skilled Nursing Facility
RP	Trip from the Patient's Residence to a Physician's Office
RX	Trip from Patient's Residence to MD to Hospital
SH	Trip from the Scene of an Accident to a Hospital
SI	Accident Scene, Acute Event/Transfer Airport, Heli Pad

TN	Rural Area

Billing requirements for ambulance claims:

- Providers must bill the transport procedure codes with the appropriate modifier.
- Ground mileage must be billed with the appropriate transport procedure code and the appropriate modifier.
- Providers who submit a claim for transport procedure codes without a modifier will be denied for invalid/missing modifier.
- Provider who bill mileage alone will be denied for invalid/inappropriate billing.
- Mileage will only be padi when billed in conjunction with a paid transport procedure code.
- A second trip may be reimbursed if the member is transferred from the first hospital to another hospital on the same day in order to receive appropriate treatment. The second trip must be billed with the appropriate "Trip from One Hospital to Another Hospital" modifier.
- Providers must complete field 32 of the CMS 1500 claim form on **paper** claims. This must include:
    - The full address for the origin and destination for all ambulance services.
    - The time of departure from origin and arrival time at the destination
- Providers must attach trip notes through a 275 attachment transaction using "**AM**" report code on **EDI** claims and the notes must include:
    - The full address for the origin and destination for all ambulance services.
    - The time of departure from origin and arrival time at the destination
- Procedure codes for air ambulance trips A0430, A0431, and A0436 must be billed with a "TN" modifier if the trip originated in a rural area in order to be paid the appropriate rural rate.
- Air ambulance should not bill supplies separately.
- Only "R" codes from the ICD-10 manual should be used. This includes emergency medical technicians (EMTs). EMTs are to report observed signs and symptoms utilizing the ICD-10 "R" codes. Any historical diagnosis information reported by a member, the member's family, or a caregiver to the EMT should be recorded in the chart notes.
- Ambulance providers should use modifiers GY, QL or TQ when billing ambulance 911 non-emergency services to indicate that the services performed were non-covered services. Claims billed with these modifiers deny as a non-covered service:

Modifier	Description
GY	An item or service is that statutorily excluded

QL	The Patient is pronounced dead after the ambulance is called bur before transport.
TQ	Basic life support by a volunteer ambulance provider

- Ambulance providers are allowed to bill enrollees for non-covered services only if the enrollee was informed prior to transportation, verbally and in writing, that the service would not be covered by AmeriHealth Caritas Louisiana and the enrollee agreed to accept the responisiblity for payment.

- The provider is required to obtain a signed statement or form which documents that the enrollee was verbally informed of the out-of-pocket expense.

- The following modifiers are required to be used when billing for transports that are non-covered services by Medicare:

Modifier	Description
DD	Clinic/Free-standing Facility to Clinic/Free-standing Facility
DE	Clinic/Free-standing Facility to Nursing Home
DP	Clinic/Free-standing Facility to Physician
DR	Clinic/Free-standing Facility to Residence
ED	Nursing Home to Clinic/Free-standing Facility
EP	Nursing Home to Physician
ER	Nursing Home to Residence
HP	Hospital to Physician
NP	Skilled Nursing Facility to Physician
PD	Physician to Clinic/Free-standing Facility
PE	Physician to Nursing Home
PN	Physician to Skilled Nursing Facility
PP	Physician to Physician
PR	Physician to Residence
RD	Residence to Clinic/Free-standing Facility
RE	Residence to Nursing Home
RP	Residence to Physician

- The above modifiers may only be used with procedure codes A0425-A0429 and A0433-A0434 to allow the claim to bypass the Medicare edit for non-emergency transports only and should be billed as non-emergency.

- Emergency ambulance claims, that are not treatment-in-place, are only payable with a destination modifier of H, I, or X. Valid treatment-in-place ambulance claim modifiers are identified in the Treatment-in-Place section.

Please refer to the **Ambulance Fee Schedule** located on the Louisiana Medicaid for emergency ground, emergency air fees, regions, billable codes and modifiers for rural areas.

"Ambulance 911-Non-emergency" services are not covered. If the enrollee's medical condition does not present itself as an emergency in accordance with the criteria in the **AmeriHealth Caritas Louisiana Provider Handbook**, the service may be considered a non-covered service.

Please refer to AmeriHealth Caritas Louisiana Ambulance Services reimbursement policy for more details.

Ambulatory Surgery – (Outpatient Hospital)

Hospitals are required to bill outpatient ambulatory surgery charges for the specified surgeries on the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules using revenue code **490-Ambulatory Surgery Care**. All other charges associated with the surgery (e.g., observation, labs, radiology) must be billed on the same claim as the ambulatory surgery charges.

Revenue code 490 for the primary surgical procedure is the only revenue code paid and is paid at the flat rate for the surgical procedure from the **Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules.**

The CPT/HCPCS code for the primary procedure must be entered in the field 44 of the UB-04 form.

For minor surgeries that are medically necessary to be performed in the hospital operating room, but the associated CPT code is not included in the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules, providers are required to bill using revenue code **361-Operating Room Services-Minor Surgery** along with all other charges associated with the surgery.

Ambulatory Surgical Centers (ASC)-Non-Hospital

Ambulatory Surgical Centers (ASC) –(Non-Hospital) are required to bill on CMS 1500 or 837 Format.

Providers are to bill only one surgical procedure (the highest compensable surgical code) per outpatient surgical session with place of service code 24.

Depending on the surgical procedure performed it may require a prior authorization. Please refer to the AmeriHealth Caritas Louisiana **PA Lookup tool** to find out if the procedure requires a prior authorization.

If providers are looking to perform a procedure in the Ambulatory Surgical Center that is **not** on the **Louisiana Medicaid Ambulatory Surgical Center Fee Schedule**, the provider must obtain a prior authorization and a rate negotiation prior

to the procedure being rendered. Failure to obtain a prior authorization for procedures not on the Ambulatory Surgical Center Fee Schedule will result in claim denial.

Please refer to AmeriHealth Caritas Louisiana Ambulatory Surgery Center reimbursement policy for more details.

Anesthesia Services

Claims related to anesthesia services shall include the following:

- Anesthesia time begins when the provider begins to prepare the enrollee for induction and ends with termination of the administration of anesthesia.
- Time spent in pre- and postoperative care may not be included in the total anesthesia time.
- Anesthesia minutes must be billed on the claim to prevent claim denial.
- Anesthesia for multiple surgical (non-OB) procedures in the same anesthesia session must be billed on one claim line using the most appropriate anesthesia code with the total anesthesia time spent reported in field 24G on the CMS 1500 claim form. The only secondary procedures that are not to be billed in this manner are tubal ligations and hysterectomies.
- The delivering physician should submit a claim for the delivery and anesthesia on a single claim line with modifier.

Anesthesia-Dental

Reimbursement is $20.00 per time unit (each time unit is equal to 15 minutes) for general anesthesia administered during dental procedures.

To receive the additional reimbursement, modifier 23 must be appended to the anesthesia CPT code 00170 in addition to other appropriate anesthesia modifiers when a dental procedure is performed. The general anesthesia reimbursement formula has been revised to calculate the additional reimbursement. The additional reimbursement will be applied after all other calculations take place.

Facility reimbursement, where the dental procedures are performed, may receive an additional reimbursement of at least $400.00 per procedure.

To receive reimbursement, CPT code 41899 must be used and the procedure must take place in a hospital outpatient setting.

Anesthesia-Maternity Related

The delivering physician is required to use CPT codes in the Surgery Maternity Care and Delivery section of the CPT manual to bill for maternity-related anesthesia services.

Reimbursement for these services is a flat fee, except for general anesthesia for vaginal delivery.

The following modifiers are required to be used when providing maternity-related anesthesia services:

Modifier	Servicing Provider	Service Performed
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
QX	CRNA	CRNA service with medical direction* by an anesthesiologist
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist
47	Delivering Physician	Anesthesia provided by delivering physician
52	Delivering Physician or Anesthesiologist	Reduced services
QS	Anesthesiologist or CRNA	Monitored anesthesia care service The QS modifier is a secondary modifier only and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider did not introduce the epidural for anesthesia but did monitor the enrollee after catheter placement.

Reimbursement for maternity-related procedures, other than general anesthesia for vaginal delivery, is a flat fee. Minutes are required to be reported on all maternity-related anesthesia claims. Providers are required to follow the chart below when billing for maternity-related anesthesia.

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Vaginal Delivery General Anesthesia	01960	Valid Modifier	Formula	Anesthesiologist performs complete service, or direction of the CRNA
				CRNA performs complete service with or without direction by Anesthesiologist
Epidural for Vaginal Delivery	01967	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery only (epidural or general)	01961	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery after Epidural, for planned vaginal delivery	01967 + 01968	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Cesarean Hysterectomy after Epidural and Cesarean Delivery	01967 + 01969	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Epidural – Vaginal Delivery	59409 59612	47	Fee for delivery plus additional reimbursement for anesthesia	Delivering physician provides the entire service for vaginal delivery
Epidural – Vaginal Delivery	59409 59612	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Epidural – Vaginal Delivery	01967	AA and 52	Flat Fee	Introduction only by anesthesiologist
Epidural – Vaginal Delivery	01967	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by anesthesiologist or CRNA
Cesarean Delivery	59514 59620	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Cesarean Delivery – after Epidural	01961	AA and 52	Flat Fee	Introduction only by the anesthesiologist
Cesarean Delivery-following Epidural for planned vaginal delivery	01967 + 01968	AA and 52	Flat Fee plus add-on	Introduction only by the anesthesiologist
Cesarean Delivery – after Epidural	01961	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by the anesthesiologist or CRNA
Cesarean Delivery-following Epidural for planned vaginal delivery	01967 + 01968	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee plus add-on	Monitoring by the anesthesiologist or CRNA

When an add-on code is used to fully define a maternity-related anesthesia service, the date of delivery is required to be the date of service on claims for both the primary and add-on code.

An add-on code in and of itself is not a full service and typically cannot be reimbursed separately to different providers. The exception is when more that one provider performs services over the duration of labor and delivery.

Anesthesia-Pediatric Moderate (Conscious) Sedation

Moderate sedation is covered and may be billed for enrollees from birth to age 13. Exceptions to the age restriction are made for children who have severe developmental disabilities from age 14 to age 20.

Claims for enrollees 21 years of age or older are **not** covered and should not be billed.

The following services for moderate sedation are allowed but are not to be reported/billed separately:

- Assessment of the enrollee (not included in intra-service time);
- Establishment of intravenous (IV) access and fluids to maintain patency, when performed;
- Administration of agent(s);
- Maintenance of sedation;
- Monitoring of oxygen saturation, heart rate and blood pressure; and
- Recovery (not included in intra-service time).

A second physician other than the healthcare professional performing the diagnostic or therapeutic when the second physician provides moderate sedation in a facility setting (e.g., hospital, outpatient hospital, ambulatory surgical center, skilled nursing facility) is a reimbursable service. However, moderate sedation services performed by a second physician in a non-facility setting (e.g., physician office, freestanding imaging center) should not be reported/billed.

Anesthesia-Surgical

Procedure codes in the Anesthesia section (not the Surgery section) of the CPT manual are to be used to bill for surgical anesthesia procedures and are billable only for an anesthesiologist or certified registered nurse anesthetist (CRNA). Administration of anesthesia by the provider performing the surgical procedure for a non-obsetrical surgery is not covered and should not be billed.

Reimbursement for moderate sedation and maternity-related procedures, other than general anesthesia for vaginal delivery, will be a flat fee.

Reimbursement for surgical anesthesia procedures will be based on formulas utilizing base units, time units (1= 15 min) and a conversion factor as identified in the Anesthesia Fee Schedules.

Minutes must be reported on all anesthesia claims except where policy states otherwise.

The following applicable modifiers are required when billing 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
23	Anesthesiologist/ CRNA	Unusual anesthesia (for anesthesia procedure code 00170 only)

The following are accepted billings of modifiers:

- Modifiers which can stand alone: AA and QZ
- Modifiers which need a partner QK, QX, and QY
- Valid modifier combinations: QK and QX, or QY and QX
- Modifier 23 (CPT code 00170 only), **in addition** to modifiers above

Anesthesia for Tubal Ligation or Hysterectomy

Anesthesia reimbursement for tubal ligations and hysterectomies is formula-based, except for anesthesia for cesarean hysterectomy (CPT code 01969).

The reimbursement for CPT codes 01967 and 01969, when billed together, is a flat fee. CPT code 01968 is implied in CPT code 01969 and should not be placed on the claim form if a cesarean hysterectomy was performed after C-section delivery.

Please refer to AmeriHealth Caritas Louisiana Anesthesia reimbursement policy for additional details.

Applied Behavior Analysis (ABA) Therapy

The TF modifier must be added to the procedure code when billing intermediate level of care for a state-certified assistant behavior analyst (SCABA).

ABA provider groups must include the ABA group's NPI in field 33 of the CMS 1500 and the ABA licensed practitioner's NPI in field 24J.

When services are rendered at **different places of service** for ABA therapy but are performed on the same member, by the same rendering provider, on the same date of service, and the same code/modifier combination, providers are required to bill on one claim form and indicate the **accurate place of service code** in field 24B of the CMS 1500 **for each billed line** to prevent a "CDD-Definite Duplicate Claim" denial.

The codes listed below are the only allowed services to be billed for **telehealth** ABA therapy. They must be appended with modifier 95, and must have either place of service 02 (other than home) or place of service 10 (home).

CPT Codes	
97151	97155

97152	97156
97153	97157
97154	97158

When billing for ABA services, the rendering provider on the claim form must be the provider that provided supervision for those services and signed documentation indicating that they supervised the services being billed for on the claim.

Assistant Surgeon/Assistant at Surgery

Physicians serving as the assistant surgeon are to use the modifier "80" on the procedure code(s) representing their services. Procedure code(s) must be identical to those billed by the primary surgeon.

Advanced practice registered nurses, certified nurse midwives, and physician assistants are to use the modifier "AS" when reporting their services as the only assistant at surgery.

Please refer to AmeriHealth Caritas Louisiana Assistant Surgeon reimbursement policy for additional details.

Audiology

Payment for the following audiology codes is restricted to one per recipient per 180 days:

92550	92557	92570	92577
92552	92563	92571	92579
92553	92565	92572	92582
92555	92567	92575	92583
92556	92568	92576	92584

After approval of cochlear implant(s) has been granted, the hospital should bill for the device(s) by submitting the the appropriate HCPCS code for the device(s) on a CMS 1500 (separately from the per diem hospital bill on the UB-04).

Reimbursement is made to the hospital for both the device and the per diem.

Behavioral Health

Basic behavioral health services are covered, which include but are not limited to screening, prevention, early intervention, medication, and referral services as defined the Medicaid State Plan.

Behavioral health services performed in an 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. Behavioral Health services are billed on the CMS 1500 claim form or electronically in the 837 format.

Coordinated System of Care (CSoC) Behavioral Health claims (ages 5-20) should be submitted to Magellan Healthcare. For information call 1-800-424-4489 or TTY 1-800-846-5277.

If age modifiers are included with the codes listed on the Specialized Behavioral Health Fee Schedule (SBHFS), then they are required in addition to all other applicable modifiers from the SBHFS for claims to be paid correctly.

Behavioral Health-CSoC Claims

Submitting Claims During Month of CSoC Referral:

- If an enrollee is receiving behavioral health services and a referral is made for CSoC services after the FIRST calendar day of the month, the provider (excluding CSoC service providers) should submit service claims to AmeriHealth Caritas Louisiana until the end of the month.
- If the enrollee remains in the CSoC eligibility/assessment process, or has been determined eligible, by the first calendar day of the following month, all behavioral health service claims should be submitted to the CSoC contractor (Magellan).
- Providers should check the Electronic Medicaid Eligibility Verification System [eMEVS] to determine if AmeriHealth Caritas Louisiana is responsible for the payment of claims.
- Providers are encouraged to check eMEVS on every date of service to verify a member's eligibility and to identify if AmeriHealth Caritas Louisiana is responsible for the date of service.
- A member's eligibility does not routinely change during the middle of the month. There are retroactive corrections that can occur that may impact claims and responsibility.

Submitting Claims During Months of CSoC Enrollment:

For any month that a recipient is enrolled in CSoC on the **first** calendar day of the month, Magellan is responsible for paying providers for specialized behavioral health services rendered during the entire month.

Submitting Claims During Month of CSoC Discharge:

- During the month that an enrollee is discharged from CSoC, all specialized behavioral health service providers should submit claims to Magellan through the end of that month. AmeriHealth Caritas Louisiana assumes responsibility for payment of all specialized behavioral health services on the **first** calendar day of the following month.
- **Exclusions:**
    - Payment to providers for the provision of one of the five CSoC waiver services (i.e., Parent Support and Training, Youth Support and Training, Independent Living/Skills Building, Crisis Stabilization or Respite Care) are the responsibility of Magellan for any date of service upon which a child/youth is enrolled inCSoC. AmeriHealth Caritas Louisiana is not responsible for payment to providers for the provision of waiver services to CSoC enrolled recipients.

- Payment to providers for the provision of residential treatment, including Psychiatric Residential Treatment Facilities (PRTF), Therapeutic Group Homes (TGH) and Substance Use Residential treatment is not the responsibility of Magellan for any date of service. AmeriHealth Caritas Louisiana retains responsibility for the payment of providers for the provision of these services to CSoC enrolled recipients.
- Payment to providers for the provision of Inpatient Psychiatric Treatment will be determined based upon which Plan was responsible (per the above guidance) as of the recipient's admission date. The Plan maintains responsibility for payment throughout the period that was prior authorized, or through the date of discharge, whichever occurs first.
- Members enrolled with Magellan continue to receive their physical health services from AmeriHealth Caritas Louisiana or fee for service Medicaid.

Behavioral Health Non-CSoC Claims

Please refer to the electronic Medicaid Eligibility Verification System (eMEVS) to identify whether the recipient has (1) physical health, specialized behavioral health services, and non-emergency medical transportation (NEMT) through a Healthy Louisiana Plan (**Example 1** below), or (2) specialized behavioral health and NEMT benefits **only** through a Healthy Louisiana Plan (**Example 2** below).

For these recipients, all **non**-specialized behavioral health claims should be directed to traditional Medicaid (the fiscal intermediary) or the primary payer, such as Medicare, if Medicaid is secondary.

Example 1 – Physical Health, Specialized Behavioral Health and NEMT

Health Benefit Plan Coverage

Benefit	Service Type Code	Insurance Type	Plan Coverage Description
Active Coverage	Health Benefit Plan Coverage	Medicaid	Eligible for Medicaid on Plan Date. **Plan Begin Date** 02/01/2015
Deductible	Health Benefit Plan Coverage	Medicaid	Health Plan Base Deductible is $0 for In Plan Network and Out of Plan Network.
Benefit Description	Health Benefit Plan Coverage	Medicaid	PREFERRED LANGUAGE: ENGLISH
Managed Care Coordinator	Medical Care	Medicaid	BAYOU HEALTH PLAN PHARMACY PBM IS PERFORMRX **Managed Care Organization** Name of Bayou Health Plan **Telephone** Phone Number for Bayou Health Plan
Managed Care Coordinator	Specialized Behavioral Health Care	Medicaid	BAYOU HEALTH PLAN **Managed Care Organization** Name of Bayou Health Plan **Telephone** Phone Number for Bayou Health Plan
Managed Care Coordinator	Dental Care	Medicaid	DENTAL BENEFITS PLAN MANAGER **Payer** MCNA INSURANCE COMPANY **Telephone** (855) 701-6262 **URL** https://portal.MCNA.net

Example 2 – Specialized Behavioral Health and NEMT Only

Health Benefit Plan Coverage

Benefit	Service Type Code	Insurance Type	Plan Coverage Description
Active Coverage	Health Benefit Plan Coverage	Medicaid	Eligible for Medicaid on Plan Date. **Plan Begin Date** 02/01/2015
Deductible	Health Benefit Plan Coverage	Medicaid	Health Plan Base Deductible is $0 for In Plan Network and Out of Plan Network.
Benefit Description	Health Benefit Plan Coverage	Medicaid	PREFERRED LANGUAGE: ENGLISH
Managed Care Coordinator	Specialized Behavioral Health Care	Medicaid	BAYOU HEALTH PLAN **Managed Care Organization** Name of Bayou Health Plan **Telephone** Phone Number for Bayou Health Plan
Managed Care Coordinator	Dental Care	Medicaid	DENTAL BENEFITS PLAN MANAGER **Payer** MCNA INSURANCE COMPANY **Telephone** (855) 701-6262 **URL** https://portal.MCNA.net

Behavioral Health-Professional Claims (non-emergency)

Licensed Mental Health Professionals (LMHPs):

- Professional claims for LMHPs should be submitted to AmeriHealth Caritas Louisiana (for both types of examples from eMEVS listed above) or the primary payer if Medicaid is secondary. LMHPs include the following providers:
    - Psychiatrists.
    - Doctor of Osteopathy (DO) (psychiatric specialty only).
    - Medical or Licensed Psychologist.
    - Licensed Clinical Social Worker (LCSW).
    - Licensed Professional Counselors (LPC).
    - Licensed Marriage and Family Therapist (LMFT).
    - Licensed Addiction Counselors (LAC).
    - Nurse Practitioner and Nurse Practitioner Group (psychiatric specialty only).
    - Clinical Nurse Specialist (psychiatric specialty only).
    - Physician Assistant (psychiatric specialty only).

Non-Licensed Mental Health Professionals:

- Professional claims for providers who are **not** LMHPs should be submitted to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients enrolled in AmeriHealth Caritas Louisiana for specialized behavioral health services only (Example 2 from eMEVS).

Behavioral Health-Facility Claims (non-emergency)

General Hospital:

- Facility claims, inclusive of all ancillary charges, for general hospitals, should be billed to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) regardless of rendering provider, or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS.

Freestanding Mental Health Hospital or Distinct Part Psychiatric Unit (DPPU):

- Facility claims, inclusive of all ancillary charges, for freestanding mental health hospitals and DPPU should be billed to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) regardless of rendering provider. This distinction makes it imperative that DPPU claims are not billed using the coding for the associated general hospital. The DPPU unique coding must be submitted on the claim.

Behavioral Health-Lab and Radiology Claims

General Hospital or Free Standing Lab:

- All lab and radiology services provided in a general hospital (inpatient or outpatient) or in a free standing lab should be submitted to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for members with only Specialized Behavioral Health listed in eMEVS.

Freestanding Mental Health Hospital or DPPU:

- Claims that include lab and radiology services should be submitted to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) **only** when billed as part of an inpatient psychiatric hospital stay (freestanding or DPPU

Behavioral Health-Federally Qualified (FQHC) and Rural Health Centers (RHC) Claims

LMHP Rendering Provider:

- FQHC and RHC providers should submit claims to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) **only** if a behavioral health service was provided during the encounter **and** an LMHP is indicated as the rendering provider on the claim. If a recipient is seen by an LMHP and non-LMHP during the same encounter, the LMHP should be indicated as the rendering provider on the claim, and it should be sent to AmeriHealth Caritas Louisiana (both eMEVS eamples listed above)

Non-LMHP Rendering Provider:

- FQHC and RHC providers should submit any claim without an LMHP listed as the rendering provider on the claim to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or LDH's fiscal intermediary for recipients with only Specialized Behavioral Health listed in eMEVS.

The following provider types and provider specialties must render a behavioral health specific service as listed in the **Specialized Behavioral Health Fee Schedule** in order to bill a behavioral health encounter H2020:

Provider Type	Provider Specialty
31	6A, 6B, 6C, 6D, 6E, 6F
AK	8E
AH	8E
73	73

Provider Type Description	Provider Specialty Description	LDH PT TYPE	LDH ST TYPE
Doctor of Philosophy	Neuropsychologist	31	6A
Doctor of Philosophy	Psychologist Clinical	31	6A
Doctor of Philosophy	Psychologist Counseling	31	6B
Doctor of Philosophy	Psychologist Developmental	31	6D
Doctor of Philosophy	Psychologist Non Declared	31	6E
Doctor of Philosophy	Psychologist Other	31	6F
Doctor of Philosophy	Psychologist School	31	6C
Doctor of Psychology	Neuropsychologist	31	6A
Doctor of Psychology	Psychologist Clinical	31	6A
Doctor of Psychology	Psychologist Counseling	31	6B
Doctor of Psychology	Psychologist Developmental	31	6D
Doctor of Psychology	Psychologist Non Declared	31	6E
Doctor of Psychology	Psychologist Other	31	6F
Doctor of Psychology	Psychologist School	31	6C
Licensed Prof Counselors	Professional Counselling	AK	8E
Licensed Marriage Family Thera	Marriage and Family Therapy	AH	8E
Licensed Clin Social Worker	Licensed Clin Social Worker	73	73

Billing guidelines for above provider types and specialties:

- T1015 or D0999 cannot be billed. Encounters will deny (provider not eligible).
- If an E/M service detail line (procedure codes between 90792 or 99202 through 99215) is submitted with an accepted H2020 and specialized behavioral health (SBH) procedure code line, the E/M service detail line ONLY will deny.
- If there are no accepted SBH service detail lines, the encounter will deny (no eligible service).
- If there is not an accepted all-inclusive code H2020, the encounter will deny (no eligible service).

The rendering provider types and specialties below billing H2020 must include an accepted E/M detail line (procedure codes between 99202 thru 99215) or accepted SBH service detail line. SBH services are identified in the SBH Fee Schedule

Provider Type	Provider Specialty
20	26, 2W
78	26

93	26
94	26
31	6G

Provider Type Description	Provider Specialty Description	LDH PT TYPE	LDH ST TYPE
Doctor of Philosophy	Medical Psychologist	31	6G
Doctor of Psychology	Medical Psychologist	31	6G
Medical Doctor	Pediatric Psychiatry	20	26
Medical Doctor	Psychiatry	20	26
Osteopath	Pediatric Psychiatry	20	26
Osteopath	Psychiatry	20	26
Medical Doctor	Addiction Medicine	20	2W
Osteopath	Addiction Medicine	20	2W
Advance Registered Nurse Practitioner	Psych Mental Health Nursing	78	26
Nurse Practitioner	Psych Mental Health Nursing	78	26
Nurse Practitioner	Psychiatric	78	26
Clinical Nurse Specialist	Clinical Nurse Psych	93	26
Physician's Assistant	Psychiatry	94	26

Modifier	Description
AF	Psychiatrist
AF	Psychiatrist – Addictionologist
AF	Psychiatrist – Psychiatry, Neurology, Addiction, Medicine
SA	Nurse Practitioner (NP) – APRN
SA	Clinical Nurse Specialist (CNS) – APRN

SA	Physician's Assistant (PA)
HP	Medical Psychologist

Billing guidelines for above provider types and specialties:

- There must be an accepted H2020 line, and at least one accepted E/M detail line (procedure codes 99202 throught 99215), or at lease one accepted SBH service detail line.
- If there are no accepted/paid detail lines with at least one E/M service detail line or at least one SBH service detail line, the encounter will deny as no eligible service
- Both SBH and E/M codes may be reported and accepted on the encounter.
- If H2020 is not accepted, the encounter will deny as no eligible service.
- The above provider type/specialty combinations are the only behavioral health providers allowed to be reimbursed for claims with an evaluation and management HCPCS code as the only detailed line. All other behavioral health provider type/specialty combinations require at lease one qualified psychiatric service included as a detailed line on the claim.
- These types and specialties above are allowed to bill the T1015 as well as H2020 (with above guidelines) when providing both physical and behavioral encounters on the same date but they must still adhere to filing guidelines of submitting a separate claim form with T1015 on the first line with detail lines below it and H2020 being the first line on the separate claim form with detail lines below it.

Behavioral Health-Emergency Department (ED) Claims

LMHP Rendering Provider:

- Only professional claims for an LMHP for services provided as part of an ED stay should be submitted to AmeriHealth Caritas Louisiana (both eMEVS examples listed above).

Non-LMHP Rendering Provider:

- Hospitals should submit ED facility claims to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS.

- All professional claims associated with an ED stay should be submitted to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for members with only Specialized Behavioral Health listed in eMEVS, **except** when the rendering provider is an LMHP.

Behavioral Health-Inpatient Acute Detox Claims

General Hospital:

- Providers should submit claims for acute detox to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS if the service is performed in a general hospital.

Freestanding Mental Health Hospital or DPPU:

- Providers should submit claims for acute detox to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) if services were performed in a freestanding mental health hospital or DPPU.

Behavioral Health-CPT Codes for Neuropsychological Testing and Behavioral Assessment Claims

Procedure codes 96132, 96133, 96136, 96137, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170 and 96171 are payable to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) when rendered by an LMHP and where applicable prior authorization or pre-certification requirements are met.

Behavioral Health-Non-Emergency Medical Transportation Cost

Upon referral by a provider, all non-emergency medical transportation (NEMT) for eligible members to and from a contracted provider (or providers operating under an approved single/ad hoc case agreement) shall be reimbursed through AmeriHealth Caritas Louisiana's non-emergency transportation broker,Verida.

Behavioral Health-Personal Care Services (PCS)

Behavioral health PCS services must be billed per 15 minutes unit and reimbursement is at a flat rate, with the exception of the per diem rate for which the unit is a per day rate.

If the behavioral health PCS provider fails to use the electronic visit verification (EVV) system or does not use the system in compliance with LDH's policies and procedures for EVV, claims will be denied.

Behavioral Health-Pharmacy Claims

All Pharmacy Services including behavioral health medications will be provided through AmeriHealth Caritas Louisiana (Example 1 from eMEVS), traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS, or the primary payer if Medicaid is secondary.

Behavioral Health-Expansion of Mental Health Professionals

Effective dates of service August 1, 2024 and after, services delivered by provisionally licensed professional counselors (PLPC), provisionally licensed marriage and family therapists (PLMFT), and licensed master social workers (LMSW) are covered and they are allowed to bill the following CPT codes with modifier **U4** for **LMSW** and modifier **UA** for **PLPC** and **PLMFT**.

Code	Description	Age
90785	INTERACTIVE COMPLEXITY, ADD ON	0+
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	0+
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT PRESENT	0+
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT PRESENT	0-20
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT PRESENT	21+
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT PRESENT	0-20
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT PRESENT	21+
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES	0-20
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES	21+
90840	PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTE ADD ON	0-20

Code	Description	Age
90840	PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTE ADD ON	21+
90846	FAMILY PSYCHOTHERAPY WITHOUT PATIENT PRESENT	0+
90847	FAMILY PSYCHOTHERAPY WITH PATIENT PRESENT	0+
90853	GROUP PSYCHOTHERAPY	0+
96156	HEALTH BEHAVIOR ASSESSMENT/REASSESSMENT	0-20
96156	HEALTH BEHAVIOR ASSESSMENT/REASSESSMENT	21+
96158	HEALTH BEHAVIOR INTERVENTION, INDIVIDUAL, FACE-TO-FACE; FIRST 30 MINUTES	0-20
96158	HEALTH BEHAVIOR INTERVENTION, INDIVIDUAL, FACE-TO-FACE; FIRST 30 MINUTES	21+
96159	HEALTH BEHAVIOR INTERVENTION, INDIVIDUAL, FACE-TO-FACE; EACH ADDITIONAL 15 MINUTES	0-20
96159	HEALTH BEHAVIOR INTERVENTION, INDIVIDUAL, FACE-TO-FACE; EACH ADDITIONAL 15 MINUTES	21+
96164	HEALTH BEHAVIOR INTERVENTION, GROUP, FACE-TO-FACE; FIRST 30 MINUTES	0-20
96165	HEALTH BEHAVIOR INTERVENTION, GROUP, FACE-TO-FACE; EACH ADDITIONAL 15 MINUTES	0-20
96164	HEALTH BEHAVIOR INTERVENTION, GROUP, FACE-TO-FACE; FIRST 30 MINUTES	21+
96165	HEALTH BEHAVIOR INTERVENTION, GROUP, FACE-TO-FACE; EACH ADDITIONAL 15 MINUTES	21+
96167	HEALTH BEHAVIOR INTERVENTION, FAMILY WITH PATIENT PRESENT, FACE-TO-FACE; FIRST 30 MINUTES	0-20

96167	HEALTH BEHAVIOR INTERVENTION, FAMILY WITH PATIENT PRESENT, FACE-TO-FACE; FIRST 30 MINUTES	21+
96168	HEALTH BEHAVIOR INTERVENTION, FAMILY WITH PATIENT PRESENT, FACE-TO-FACE; EACH ADDITIONAL 15 MINUTES	0-20
96168	HEALTH BEHAVIOR INTERVENTION, FAMILY WITH PATIENT PRESENT, FACE-TO-FACE; EACH ADDITIONAL 15 MINUTES	21+

PLPCs, PLMFTs and LMSWs shall practice within the scope of practice of their respective Louisiana professional licensing board and shall be rendering providers only. Any claim billed independently by a PLPC, PLMFT or LMSW will be denied.

Behavioral Health-Brief Emotional/Behavioral Assessment

Effective dates of service July 12, 2024 and after, brief emotional/behavioral assessment is a covered service and should be billed with CPT code 96127.

Behavioral Health-Transcranial Magnetic Stimulation (TMS)

Effective dates of service August 2, 2024 and after, TMS is covered and providers may file claims if the member meets the criteria. Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for coverage details.

The following CPT codes are the billable codes for TMS:

CPT Code	Description
90867	Therapeutic TMS treatment, initial
90868	Therapeutic TMS, subsequent
90869	Therapeutic TMS, subsequent re-determination

CPT code 90867 should be reported only once (within a 6 week period) per patient for the episode (initial planning) and not in conjunction with CPT codes 90868 or 90869.

Do not report CPT code 90869 in conjunction with 90867 or 90868.

Behavioral Health-Dialectical Behavioral Therapy (DBT)

DBT is covered for **dates of service 3/1/25 and after.**

A DBT practitioner may receive reimbursement for the DBT service, when delivier DBT as par of a DBT team that is:

- Trained and qualified to deliver DBT demonstrated by either:
    - Certification from the DBT-Linehan Board of Certification (DBT-LBC)
    - OBH-approved DBT qualification

    - Engaged consistently and in good standing in an OBH-sponsored DBT training program that will lead to an OBH-approved DBT qualification, following the agency and practitioner's completion of the initial didactic training sessions, while consultation with an OBH-approved DBT trainer

- Following initial qualification to deliver DBT, the team also must complete periodic fidelity reviews
- Only direct staff face-to-face time with the individual or family may be billed.
- DBT is a face-to-face intervention with the individual present.
- Telehealth delivery is allowed if it includes synchronous, interactive, real-time electronic communication comprising both audio and visual elements
- Services provided using telehealth must be identified on claims submission by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home)
- The DBT model is delivered in three (3) modalities:
    - Individual therapy
    - DBT skills training group sessions
    - Therapeutic coaching (24-hour availability), not billed
- The group therapy session must be co-led by two (2) DBT practitioners, and must be delivered for a minimum of 90 minutes; in standard practice the DBT skills training group typically has a duration of 120-150 minutes
- For DBT skills training groups which are co-led by two practitioners, one practitioner submits the group therapy claim for a client, with progress notes to be co-signed by both of the group co-leaders
- The co-leader of the DBT skills training group who does not submit the claim, may not have completed the DBT qualification, but must complete initial DBT didactic training within six (6) months of beginning to co-lead DBT skills training groups
- LMSWs, PLPCs and PLMFTs may not directly bill for services provided to an enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice act

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.

If chemotherapy is done during an observation stay, even if the AmeriHealth Caritas Louisiana PA Lookup Tool CPT/HCPCS states an authorization is needed for the chemotherapy code it would not require an authorization during the 48-hour observation stay.

Chiropractic Care EPSDT (Ages 0-20)

Claims for chiropractic services are billed on a CMS 1500 or via 837 format.

HCPCS modifier “AT” (Acute Treatment) may bebilled with spinal manipulation codes 98940 and 98941.

Community Health Workers

The codes reimbursed for services provided by Community Health Workers (CHW) are CPT procedure codes in the ‘Education and Training for Patient Self-Management’ section of the CPT Professional manual (98960, 98961 and 98962).

A CHW who provides services to more than one enrollee is required to document in the clinical record and bill appropriately using the approved codes associated with the number of people receiving the services simultaneously. This is limited to eight unique enrollees per session.. Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs) claims for CHW services may also include the following:

- T1015, H2020 or D0999
- An evaluation and management code

If an evaluation and management code is included on the FQHC or RHC claim, reimbursement will be the rate of file for the encounter visit in addition to the rate of file for the CHW services for the date of service.

If an envaluation and management code is not included on the FQHC or RHC claim, reimbursement will be the rate of file for the CHW services for the date of service.

An FQHC or RHC evaluation and management visit must be conducted within 30 days of the CHW services.

Corneal Collagen Cross-Linking

Effective dates of service May 1, 2024 and after, corneal collagen cross-linking (CXL) procedures are covered. The CXL procedure, including the riboflavin drops and administration of UV light, is approved for patients between 14-20 years of age with progressive keratoconus.

CXL can be billed using the following codes:

- 0402T: collagen cross-linking of cornea (including removal of the corneal epithelium and measurement of corneal thickness).

- J2787: riboflavin 5’-phosphate, ophthalmic solution, up to 3 mL.

Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for CXL clinical guidelines.

CPT Category (CAT) II Supplemental Reimbursement

CPT Category (CAT) II codes are supplemental tracking codes that can be used for performance measurement.

CAT II supplemental reimbursements are reimbursements payable when PCPs and specialists render and bill the services in the listing below in conjunction with a diagnosis of diabetes or hypertension.

Providers need to bill a charge of $5.00 or $10.00 according to the applicable rate for the code in the listing below to receive the full supplemental reimbursement. Reimbursement will not exceed the billed charges and providers are only reimbursed if all the criteria is met in the listing below:

CPT Cat II Code	Code Description	Rate	Requires 1 Diagnosis from Indicated Range	Age Range	Frequency Limit
2022F	Dilated retinal eye exam with evidence of retinopathy	$10	E10.10-E13.9	18+years	1 per calendar year
2023F	Dilated retinal eye exam without evidence of retinopathy	$10	E10.10-E13.9	18+years	1 per calendar year
2024F	7 standard field stereoscopic photos with evidence of retinopathy	$10	E10.10-E13.9	18+years	1 per calendar year
2025F	7 standard field stereoscopic photos without evidence of retinopathy	$10	E10.10-E13.9	18+years	1 per calendar year
2026F	Eye imaging validated to match dx from **7** standard field stereoscopic photos with evidence of retinopathy	$10	E10.10-E13.9	18+years	1 per calendar year
2033F	Eye imaging validated to match dx from **7** standard field stereoscopic photos without evidence of retinopathy	$10	E10.10-E13.9	18+years	1 per calendar year
3044F	Most recent HbA1c level less than 7.0%	$10	E10.10-E13.9	18+years	1 per calendar year
3046F	Most recent HbA1c level greater than 9.0%	$10	E10.10-E13.9	18+years	1 per calendar year
3051F	Most recent HbA1c level between **7**.0% and less than 8.0%	$10	E10.10-E13.9	18+years	1 per calendar year
3052F	Most recent HbA1c level between 8.0% and less than 9.0%	$10	E10.10-E13.9	18+years	1 per calendar year
3072F	Low risk for retinopathy {no evidence of retinopathy in prior year)	$10	E10.10-E13.9	18+years	1 per calendar year

CPT Cat II Code	Code Description	Rate	Requires 1 Diagnosis from Indicated Set	Age Range	1 Pair = 1 Green AND 1 Blue
3074F	Most recent systolic blood pressure <130mmHg	$5	E10.10-E13.9 *or* 110	18+ years	1 pair per 90 days
3075F	Most recent systolic blood pressure130-139 mm Hg	$5	E10.10-E13.9 *or* 110	18+ years	1 pair per 90 days
3077F	Most recent systolic blood pressure>=140 mm Hg	$5	E10.10-E13.9 *or* 110	18+ years	1 pair per 90 days
3078F	Most recent diastolic blood pressure <80mmHg	$5	E10.10-E13.9 *or* 110	18+ years	1 pair per 90 days
3079F	Most recent diastolic blood pressure 80-89 mm Hg	$5	E10.10-E13.9 *or* 110	18+ years	1 pair per 90 days
3080F	Most recent diastolic blood pressure >=90 mm Hg	$5	E10.10-E13.9 *or* 110	18+ years	1 pair per 90 days

Diabetes Self-Management Training

The following HCPCS codes or their successors are used to bill for DSMT services:

- G0108-Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109-Diabetes self-management training services, group session (two or more) per 30 minutes

Services provided to pregnant woment with diabetes must be billed with the "TH" modifier.

Hospitals are to bill the above HCPCS codes in the outpatient setting along with revenue code 942. These are the only HCPCS codes currently allowed to be billed with HR942.

Dialysis

Reimbursement for dialysis services must be billed using the UB 04 claim form or using the electronic submission 837I.

Epogen (or epoetin alfa) must be reported using procedure code Q4081 in conjunction with revenue code 634 and revenue code 635.

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, epoetin alfa, 100 units (for ESRD on dialysis)**. 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.

Discarded Drugs

The modifier below is used to identify drug amounts discarded/not administered to any patient. The amount administered to the patient should be billed on one line and the amount of the drug not administered (discarded) should be billed on a separate line appended with the JW modifier with the associated CPT/HCPCS code. The amount discarded is not covered and that claim line with the JW modifier will be denied.

Modifier	HCPCS Description
JW	Drug amount discared/not administered to any patient

Please refer to AmeriHealth Caritas Louisiana Discarded Drugs and Biologicals reimbursement policy for additional details.

Donor Human Milk -Inpatient

Donor human milk is reimbursed separately from the hospital reimbursement for inpatient services.

The minimum reimbursement for the donor human milk is the fee on file on the Louisiana Medicaid Durable Medical Equipment (DME) Fee Schedules.

Hospitals must bill the donor human milk claim using the HCPCS procedure code T2101 (1 unit per ounce) on a CMS 1500 claim form.

Donor Human Milk-Outpatient

Human donor milk as an **outpatient** service for use by medically vulnerable infants is covered (please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for details regarding this coverage).

Prior authorization is not required for donor human milk. Donor human milk is, however, subject to post payment medical review.

Failure to provide required documentation, or if the documentation submitted fails to establish medical necessity, will result in recoupment of the payment for the donor human milk.

Durable Medical Equipment

DME billing requirements:

- Services are billed on a CMS 1500 claim form.
- Date span should be billed as a full month (example: 01/25 – 02/25)
- Submits bills based on a 30-day monthly cycle.
- Do not bill in cases, must bill in units only.
- Bill appropriate units – (1) can is equal to a quantity of “1”.

- An “NU” modifier is used for new purchases.
- An “RR” modifier is required for all rentals.
- DME repair codes for payment consideration should be billed as follows:

    - K0739 -Repair for DME Labor per 15 minutes
    - K0739 RB-Repair for DME - Parts

- The following diabetic supplies should not be billed as DME (they are under pharmacy benefit only):
    - Diabetes glucose meters
    - Diabetic test strips
    - Continuous glucose meters
    - Transmitters and sensors
    - External insulin pumps (e.g., Cequr Simplicity, Omnipod and V-Go)
    - Control solution
    - Ketone test strips
    - Lancets and devices
    - Pen needles
    - Re-usable insulin pens
    - Syringes

NOTE: Insulin pumps requiring tubing and supplies, reservoirs and canisters are still billable as DME.

HCPCS codes for metabolic formulas require an NDC number all other enterals no longer require an NDC.

Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least 70 percent of the daily caloric intake. Nutritional supplements given between meals to boost daily protein-caloric intake or as the mainstay of a daily nutritional plan may be covered for members under age 21 where medical necessity is established.

Nutritional supplements will not be covered as described above for members age 21 years or older unless the member has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with his/her general condition.

Claims from DME providers must ensure that the ordering provider types are individuals listed on the claim form with the individual NPI. A group or clinic must not be listed as the ordering provider on claims or encounters.

For example, ordering providers cannot be physician clinics, Federally Qualified Health Clinics, Rural Health Clinics, and American Indian Clinics.

Providers must submit all required documentation listed below with an electric breast pump claim because failure to provide requiremed documentation, or documentation that fails to establish medical necessity, may result in recoupment of the payment for the device.

- Prescription from the prescribing physician for the electric breast pump;
- Education/training on breastfeeding by the prescribing physician, licensed breastfeeding practitioner or healthcare professional;
- AmeriHealth Caritas Louisiana has not purchased a breast pump within the past three years for the same delivery; and
- Completed Fillable Electric Breast Pump Request Form signed by the prescribing physician and the mother or her authorized representative.

NOTE: Single, manual and hospital-grade breast pumps are still not covered.

DME HCPCS codes listed on the **Louisiana Medical DMEPOS Fee Schedule** as "MP" are manually priced (see below):

- Claims must include appropriate HCPCS codes along with the manufacturer's suggested retail price (MSRP)
- The reimbursement for manually priced DME items and DME rentals is based on the lessor of:
  - 70 percent of the 2000 Medicare fee schedule for all procedure codes that were listed on the year 2000 Medicare fee schedule, and at the same amount for the HIPAA compliant codes which replaced them; or
  - 70 percent of the Medicare fee schedule under which the procedure code first appeared; or
  - 70 percent of MSRP amount; or
  - 70 percent of billed charges

The provider must be credentialed to provide DME services.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment Preventive Services Program)

EPSDT Periodic Screening

If an abnormality or problem is encountered during an EPSDT periodic screening and treatment is significant enough to require an additional evaluation and management (E&M) service on the same date, by the same provider, no additional E&M of a level higher than CPT code 99212 is reimbursable.

EPSDT Preventive 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).
4. Laboratory tests (including age-appropriate screenings for newborns, iron deficiency anemia, blood lead levels, dyslipidemia and sexually transmitted infections).
5. Health education (including anticipatory guidance).

- Providers must bill with the most appropriate diagnosis 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 codes are used to bill medical screenings:

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)

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 disease, strabismus, amblyopia, refractive errors, and color blindness.

The CPT procedure code to use for vision screenings is 99173 amended with EP modifier (see **EPSDT Preventive Services Fee Schedule**).

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.

The CPT procedure code to use for hearing screenings is 92551 modifier (see **EPSDT Preventive Services Fee Schedule**).

EPSDT Interperiodic Screenings

An interperiodic age-appropriate screening may only be billed if the enrollee has received an age-appropriate medical screening. If the medical screening has not been performed, then the provider must perform and bill an age-appropriate medical screening before an interperiodic screening may be performed and billed.

An interperiodic screening includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education and other age-appropriate procedures.

An interperiodic screening may be performed and billed for a required Head Start physical or school sports physical, but must include all of the components required in the EPSDT preventive periodic screening.

Documentation must indicate that all components of the screening were completed. Medically necessary laboratory, radiology, or other procedures may also be performed and may be billed separately. A well diagnosis is not required.

EPSDT-Neonatal/Newborn Screening for Genetic Disorders

If screening results are not available, or if newborns are screened prior to 24 hours of age, newborns must have another newborn screen. The newborn infant must be rescreened at the first medical visit after birth, preferably between one and two weeks of age, but no later than the third week of life. Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for more details on coverage requirements for Neonatal/Newborn Screening for Genetic Disorders.

Newborn screening for severe combined immunodeficiency (SCID) is covered under CPT code 81479. This code is only to be used for this purpose and until such a time a permanent procedure code is in place.

EPSDT-Perinatal Depression Screening

Coverage is available for perinatal depression screenings administered to an enrollee's caregiver in accordance with the American Academy of Pediatric/Bright Futures periodicity schedule. The screening can be administered from birth to 1 year during an EPSDT preventive visit, interperiodic visit, or E&M office visit.

Though the screening is administered to the caregiver, it is reimbursed under the child's Medicaid coverage. If 2 or more children under age 1 are present to care on the same day (e.g., twins or other siblings both under age 1), the provider must submit the claim under only one of the children. When performed on the same day as a developmental screening, providers must append modifier -59 to claims for perinatal depression screening.

EPSDT-Personal Care Services (PCS)

All claims for EPSDT PCS should be filed either by electronic claims submission 837P or on the CMS 1500 claim form.

Providers must bill with the T1019-EP code on the EPSDT-PCS fee schedule.

If the EPSDT PCS provider fails to use the electronic visit verification (EVV) system or does not use the system in compliance with LDH's policies and procedures for EVV, claims will be denied.

EPSDT-Laboratory

Iron deficiency anemia and blood lead testing when required are included in the medical screening fee and must not be billed separately.

Emergency Room Services

Hospital providers must bill revenue code 450 or 459 when submitting claims for outpatient emergency room services, along with the appropriate CPT code of either 99281, 99282, 99283. 99284, 99285, or 99291 . Only one revenue code 450 or 459 may be billed on the emergency room claim.

Note: 99292 is **not** covered when billed in the emergency room.

Hospital claims for emergency room services are not to be billed as a single line item. Claims must include all revenue codes (i.e., pharmacy, lab, x-rays and supplies) which were utilized in the enrollee's treatment, using the appropriate revenue code and CPT/HCPCS when applicable.

Professional claims for emergency room services must bill the appropriate CPT/HCPCS code (99281-99285 or 99291-99292).

When an emergency visit results in an inpatient admit, providers must bill all charges associated with the emergency visit on the inpatient bill.

This policy applies to enrollees admitted from the emergency department or if the enrollee has been seen in the emergency department within 24 hours either prior to admit or after the inpatient discharge.

The emergency department charges must be billed as a separate line. All associated charges for the emergency visit must be included by revenue code with the total charges for the inpatient stay.

Fluoride Varnish Application

Fluoride varnish application may be billed once every six months for eligible enrollees ages 6 months through 5 years. Providers should use the following CPT and ICD-10 codes:

CPT Code	99188	Application of topical fluoride varnish
ICD-10 Code	Z41.8	Need for fluoride varnish application

FQHC/RHC/American Indian Clinics-Therapy Services

When billing therapy services in an FQHC, RHC or American Indican Clinics, claims must be submitted as indicated below:

- The header line must be the T1015 procedure code for the encounter.
- The detailed lines must contain the specific CPT codes for each service provided on the service date.
- Only one encounter is reimbursed for therapy provided on a single date of service for the same provider. If multiple therapies are provided, all must be billed on the same claim.
- The billing provider on the claim will be the provider type 72, 79, 87, or 95.
- The rendering/servicing provider will be the physical therapist (PT 35), occupational therapist (PT 37) or speech therapist (PT 39).
- Multiple encounters with the same health profession, that take place on the same date of service, at a single location, constitute a single visit, and are limited to one encounter per day except when one of the following conditions exists:
    - After the first encounter, the enrollee suffers illness or injury requiring additional diagnosis or treatment; and
    - The enrollee has a medical visit or dental visit on the same day.

FQHC/RHC EPSDT Claim Filing Instructions

EPSDT Screening Services must be billed using the CMS 1500/837P Professional format using encounter code T1015 with modifier EP.

It is necessary to indicate the specific preventive screening services provided to support the T1015- EP encounter by entering the individual procedure code for each service rendered as the appropriate detail line.

This includes but is not limited to immunizations, vision and hearing screening, developmental screening, and perinatal depression screening performed at the time of the EPSDT preventive visit.

All claims billed using the T1015-EP must include the supporting detail procedure codes representing the services provided on the same date as the encounter or the claim will deny.

The physician, advanced practice registered nurse (APRN), or physician assistant (PA) listed as the rendering provider must be present and involved during a preventive visit.

Any care provided by a registered nurse, or other ancillary staff in a provider's office, is subject to Medicaid's 'incident to' policy and must only be providing services within the scope of their license or certification.

NOTE: The dental encounter, D0999, may be billed on the same date of services as the encounter codes T1015, T1015 TH (OB encounter), T1015 EP (EPSDT screening) and/or H2020 (Behavioral Health encounter-See Behavioral Health Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) section in this manual for more details).

FQHC/RHC Non-EPSDT Claim Filing Instructions

Claims require the submission of encounter code T1015 in conjunction with detail level procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines. If detail procedure code lines are not billed with T1015 or if any of the detail procedure codes billed are **not** on the Louisiana Medicaid Fee Schedules, encounter code T1015 will be denied.

T1015 cannot be billed as a single line claim. Claims billed with a single line item will be denied.

The entire claim will be denied if T1015 is billed with a valid detail procedure code and an invalid detail procedure code on the same claim.

If T1015 is billed with a procedure code that is not on the Louisiana Medicaid Fee Schedules the claim will be denied.

RHC/FQHCs will not be reimbursed for family planning services in addition to the encounter payment.

Maternity Care Visits – Obstetricians providing maternity care at an RHC/FQHC should append the T1015 with "TH" modifier.

RHC/FQHCs may bill for adjunct services in addition to the T1015; however, payment is not allowed when the encounter is for dental services only.

Use the correct place of service code 50 (FQHC) and code 72 (RHC) or 12 (RHC and FQHC) if the service was rendered in the member's home. If it is a telehealth service use POS 02 (if it is not in patient's home) or 10 (if it is in patient's home). Place of service 27 can be used by an RHC or FQHC when services are provided in a non-permanent location, such as a street or public area.

Home Health Services

Provider must bill on UB-04 or via 837 Format.

Bill the appropriate revenue code, procedure code and modifier for the homecare service.

Eligible procedure codes and modifiers can be found in the **Louisiana Medicaid Home Health Services Fee Schedule** and eligible revenue codes/procedure code combinations and modifiers can be found in the **Louisiana Medicaid Home Health Revenue and Procedure Codes document** under the Home Health Services Fee Schedule on the Louisiana Medicaid website.

Extended home health providers should bill a TU modifier with procedure codes S9123 or S9124 when the nursing staff has been paid an overtime rate. The TU modifier will pay at a minimum of 1.5 times the base rate for either procedure code. This modifier does not require prior authorization and may be used in addition to modifiers already authorized.

Services furnished by one nurse or home health aide to two or more beneficiaries within the same setting on the same day is reimbursed as follows:

- For the first beneficiary, Medicaid reimburses the service at the established Medicaid rate for the prior authorized CPT code/modifier combination; and
- For the second beneficiary, Medicaid reimburses the service at 50 percent of the established Medicaid rate.

The TT modifier must be added to the home heath procedure code billed on the claim to identify the service provided to more than one beneficiary in the same setting.

Effective April 1, 2024, claims submitted by providers that are not utilizing the electronic visit verification (EVV) system are denied. Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for more details on the EVV system.

Hospice

Providers must bill on a UB-04 claim form.

Applicable bill types are 811 through 828 (field 4 of the UB-04).

Claims must be submitted for payment based on the geographic location where the service(s) are rendered by entering the applicable Metropolitan Statistical Area (MSA) code on the claim.

Metropolitan Statistical Area (MSA)Codes (formerly known as Core Based Statistical Areas (CBSA) Codes)										
10780 Rapides Grant	**12940** Ascension East Baton Rouge Livingston West Baton Rouge Pointe Coupee St. Helena Iberville East & West Feliciana	**25220** Tangipahoa	**26380** Lafourche Terrebonne	**29180** Acadia Iberia Lafayette St. Martin Vermillion	**29340** Calcasieu Cameron	**33740** Ouachita Union	**35380** Jefferson Orleans Plaquemines St. Bernard St. Charles St. James St. John the Baptist St. Tammany (for dates of service prior to 10/01/24)	**43340** Bossier Caddo Webster DeSoto	**43640** St. Tammany (for dates of service 10/01/24 and after)	**99919** All Others

Value code 61 is required in the Code section of the UB-04, and the MSA code is required in the Value Code Amount section; they can be entered in either field 39, 40 or 41 of the UB-04.

Example below:

Value code 61 is required in the Code section of the UB-04, and the MSA code is required in the Value Code Amount section; they can be entered in either field 39, 40 or 41 of the UB-04.

Example below:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	61	10780 00	61	10780 00	61	10780 00

NOTE: There must be a MSA code for each revenue code (line) billed in field 42 of the UB-04.

Bill the appropriate revenue code for the hospice level of care:

- Routine Home Care (Revenue Code 651)
- Continuous Home Care (Revenue Code 652)
- Inpatient Respite Care (Revenue Code 655)
- General Inpatient Care (Revenue Code 656)

- Physician Services (Revenue Code 657) Must be accompanied by a physician procedure code.
- Service Intensity Add-On (Revenue Code 659) May only be billed during the last 7 days of the member's life and must be billed on the same claim as routine home care services.

NOTE: Date of discharge is not reimbursable (except discharge due to death)

Hysterectomy

The primary surgeon's claim requires hard-copy submission with a valid consent form and the primary surgeon is expected to share copies of the completed consent forms to facilitate ancillary provider billing for hysterectomy services.

If an ancillary provider submits a claim for hysterectomy services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

When submitting claims for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service on which the form was signed, must be the same as the name signed at the time consent was obtained. If the enrollee's name is different, the provider must attach a letter from the physician's office from which the consent was obtained. The letter must be:

- Signed by the physician;
- State that the enrollee's name has changed;
- Include the enrollee's social security number and date of birth; and
- Be attached to all claims requiring consent upon submission for claims processing.

A witness signature is needed on the hysterectomy consent form when the enrollee meets one of the following criteria:

- Enrollee is unable to sign and must indicate "x" on the signature line; or
- There is a diagnosis on the claim that indicates mental incapacity.

If a witness signs the consent form, the signature date must match the date of the enrollee's signature. If the dates do not match, or the witness does not sign and date the form, claims related to the hysterectomy will deny.

Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for exceptions when obtaining consent for a hysterectomy is unnecessary.

Immunizations/Vaccines

Providers are required to indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s) to receive reimbursement for the administration of appropriate immunizations. The listing of the vaccine on the claim form is required for federal reporting purposes.

Vaccines from the Vaccines for Children Program are available at no cost to the provider and are required to be used for Medicaid enrollees through 18 years of age. Therefore, CPT codes for vaccines available from the VFC Program at zero ($0) are reimbursed for every enrollee from birth through 18 years of age.

Single Administration

Providers must submit the appropriate CPT immunization administration code when administering one immunization.

In addition, the CPT code for the vaccine must be included on the same claim.

Multiple Administrations

When administering more than one immunization on a single date of service, providers are to bill as described for a single administration.

In addition, the appropriate procedure code(s) (Immunization administration -each additional injection/administration/vaccine) is to be listed with the appropriate number of units for the additional vaccines placed in the “units” column.

The specific vaccines are to be listed on subsequent lines. The number of vaccines listed must match the number of units listed in the “units” column.

Hard Copy Claim Filing for Greater Than Four Administrations

Providers must bill on two CMS 1500 claim forms when billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded.

The first claim must follow the instructions for billing for a single administration.

A second CMS 1500 claim form can be used to bill the remaining immunizations as described for billing for multiple administrations.

Coverage of Vaccine for Young Adult (Ages 19 through 20) and Adult (21+)

For members 19 and older, providers are to submit claims using the appropriate immunization admiministration CPT code along with the specific vaccine CPT code and include their usual and customary billed amount. Providers will be reimbursed for the vaccine and the administration based on the fee on file or the billed charge, whichever is lower.

Additional Billing Instructions for Immunizations/Vaccines

Respiratory syncytial virus (RSV) vaccines are covered and identified by the CPT procedure codes 90380 and 90381.

The above CPT codes are to be submitted for the administration of the RSV vaccines provided.

Effective **April 1, 2024**, the JYNNEOS vaccine (CPT 90611) became commercially available.

Providers administering the vaccine should follow the guidelines below when submitting claims:

Commercially Purchased Vaccine:

- Submit the claim with the billed amount that reflects the provider's cost of the vaccine.
- Reimbursement will be the lower of the billed charges or the fee on file for recipients 19 years of age and older.

Government-Provided Vaccine Stock:

- Submit the claim with a $0 billed amount.
- Reimbursement will be $0 (paid).

Effective **August 1, 2024**, coverage for the JYNNEOS vaccine has been extended to recipients 18 years of age under the VFC program.

- Claims for VFC-provided vaccine stock should be submitted with a $0 billed amount
- Reimbursement will be $0 (paid).

Please ensure proper billing practices are followed based on the source of the vaccine to ensure accurate claim processing.

Effective for dates of service **on or after August 1, 2024** the following immunization CPT codes may also be billed for the following age groups:

CPT Code	Ages
90611	18
90653	65-99
90656	6 months-18
90657	19-99
90660	6 months-18
90661	6 months-18
90662	65-99
90673	19-99

Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for more details on immunization coverage.

Infusion Therapy

Drugs administered by physician or outpatient hospital on the Louisiana Medicaid Fee Schedule will be reimbursed, but some are subjected to a prior authorization. Drugs require the provider to also bill the NDC and related NDC information. Please refer to the AmeriHealth Caritas Louisiana **Prior authorization lookup tool** to determine authorization requirements for HCPCS codes.

Failure to bill the NDC required information will result in denial (exception would be enteral formula reimbursement).

Infusion supplies can be provided by a DME provider or home care providers; nursing services are provided by home care agency.

Drugs would need to be obtained through the pharmacy benefit for any home infusion.

Nursing and supplies are covered.

Injectable Drugs

All drugs billed are required to be submitted with NDC information and may be submitted via CMS 1500 and UB-04 (depending on the place of service) or 837 electronic format. Please refer to NDC instructions in the Supplemental Information section.

The NDC number and the HCPCS code for drug products are required on the 837 format, the CMS 1500 or UB-04 for reimbursable medications. Claims submitted without NDC information and a valid HCPCS code will be denied.

Unclassified HCPCS codes such as J3490 cannot be used if an NDC has a designated HCPCS code.

In Lieu of Services (ILOS) – Physical and Behavioral Health Services

Care at Home services for members age 13 and older -Table below represents procedure codes billable under this ILOS:

CPT	Mobile Health Home Visit Description	Visit Type Description
99342	ALS Provider (Paramedic/Licensed Practical Nurse) - Includes Advanced Life Support (ALS) assessment, basic vital signs (pulse, blood pressure, pulse oximetry, temperature, weight, and respiratory rate). Advanced Level Providers can support care such as IVs, EKGs, A1C, fluid and medication administration.	New Patient Home Visit (Unscheduled)
99344	BLS Provider (EMT) - Includes basic assessment, basic vital signs (pulse, blood pressure, pulse oximetry, temperature, weight, and respiratory rate) support virtual medical assessments and no medical interventions	New Patient Home Visit (Unscheduled)
99345	BLS Provider (EMT) - Includes basic assessment, basic vital signs (pulse, blood pressure, pulse oximetry, temperature, weight, and respiratory rate) support virtual medical assessments and no medical interventions.	New Patient Home Visit (Unscheduled)

99348	ALS Provider (Paramedic/Licensed Practical Nurse) - Includes Advanced Life Support (ALS) assessment, basic vital signs (pulse, blood pressure, pulse oximetry, temperature, weight, and respiratory rate). Advanced Level Providers can support care such as IVs, EKGs, A1C, fluid and medication administration. (This is repetitive in provider proposal at same rates)	Patient Home Visit (Scheduled)
99349	ALS Provider (Paramedic/Licensed Practical Nurse) - Includes Advanced Life Support (ALS) assessment, basic vital signs (pulse, blood pressure, pulse oximetry, temperature, weight, and respiratory rate). Advanced Level Providers can support care such as IVs, EKGs, A1C, fluid and medication administration.	Patient Home Visit (Scheduled)

99350	ALS Provider (Paramedic/Licensed Practical Nurse) - Includes Advanced Life Support (ALS) assessment, basic vital signs (pulse, blood pressure, pulse oximetry, temperature, weight, and respiratory rate). Advanced Level Providers can support care such as IVs, EKGs, A1C, fluid and medication administration.	Patient Home Visit (Scheduled)
99417	Prolonged service, per additional 15-minute increments	
99211 -99215 (append applicable modifier/place of service)	Telehealth visit	E&M code billed by physician collaborating care

Chiropractic services for adults age 21 and older -Table below represents procedure codes billable under this ILOS:

Service Category	Code	Description
Evaluation and management-new patient	99202	Office or other outpatient visit for the evaluation and management of a new patient
	99203	
	99204	

	99205	
Evaluation and management – established patient	99212	Office or other outpatient visit for the evaluation and management of an established patient
	99213	
	99214	
	99215	
Spinal X-rays	72020	Radiologic examination, spine, single view, specify level
	72040	Radiologic examination, spine, cervical; 2 or 3 views
	72050	Radiologic examination, spine, cervical; 4 or 5 views
	72052	Radiologic examination, spine, cervical; 6 or more views
	72070	Radiologic examination, spine, thoracic, 2 views
	72072	Radiologic examination, spine, thoracic, 3 views
	72074	Radiologic examination, spine, thoracic, minimum of 4 views
	72080	Radiologic examination, spine, thoracolumbar, 2 views
	72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
	72110	Radiologic examination, spine, lumbosacral; minimum of 4 views
	72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views.
	72120	Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views
	72220	Radiologic examination, sacrum and coccyx, minimum of 2 views
Spinal manipulation	98940	Spinal Manipulation 1-2 Regions
	98941	Spinal Manipulation 3-4 Regions
	98942	Spinal Manipulation 5 Regions
Other treatments‡	97012	Mechanical Traction
	97014	Electrical Stimulation (unattended)
	97022	Whirlpool Therapy
	97032	Whirlpool Therapy
	97035	Ultrasound Therapy
	97110	Therapeutic Exercises
	97112	Neuromuscular Reeducation
	97116	Gait Training
	97124	Massage Therapy
	97140	Manual Therapy
	20560	Needle insertion without injection 1-2
	20561	Needle insertion without injection 3 or more muscles

Doula services – Table below represents the procedure codes billable under this ILOS.

Service	Service Code	Standard Model- Maximum Units per Pregnancy and Postpartum Period (7+1)*	Enhanced Model- Maximum Units per Pregnancy and Postpartum Period (10+1)**	Anticipated duration of visit (minutes)
Prenatal / postpartum education, non- physician	S9445	Any combination of 7	Any combination of 10	60
Birthing class, non-physician provider	S9442	Any combination of 7	Any combination of 10	60
Lactation class, non-physician provider	S9443	Any combination of 7	Any combination of 10	60
Parenting class, non-physician provider	S9444	Any combination of 7	Any combination of 10	60
Doula intrapartum support for vaginal delivery	99199 (modifier)	1	1	Flat fee

*7 + 1 = Maximum of 7 doula visits during prenatal and postpartum periods, plus 1 intrapartum support. The 7 visits can be any combination of S9442, S9443, S9444, and/or S9445.

**10 + 1 = Enhanced model. Maximum of 10 doula visits during prenatal and postpartum periods, plus 1 intrapartum support. The 10 visits can be any combination of S9442, S9443, S9444, and/or S9445.

Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns – Table below represents the procedure codes billable under this ILOS.

Service	Service Code	Maximum Units per Pregnancy and Postpartum Period
Intake, Assessment, Care Plan Development	H0002	1
Care Coordination	H0006	20
Outreach for Disengaged Enrollees	H0023	4

Outpatient lactation support – Table below represents procedure codes billable under this ILOS:

Service Category	Procedure Code	Modifier	ICD-10	Description
Lactation Support Provider Visit	S9445	33	Z39 .1	Patient education, non-physician provider, individual session
Lactation Classes	S9443		Z39.1	Lactation classes, non-physician provider; group sessions must be at least 60 minutes

Doula providers will meet outpatient lactation support policy requirements to receive reimbursement for lactation support visits (S9445, modifier 33).

Outpatient lactation consultant services provided using telemedicine will be identified on claims and encounters by appending the modifier "95" to the applicable procedure code and indicating place of service (POS) 02 or 10. Claims that do not have both the correct POS and modifier present on the claim.

Remote patient monitoring – Table below represents procedure codes billable under this ILOS:

Procedure Code	Description	Billing Limits
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Reimbursable once per episode of care (every 9 months during pregnancy)
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Billable every 30 days **Note**: This code or 99199 may be used but not both codes for the same member.
99199	Unlisted special service, procedure, or report- This code with appropriate modifiers may be used as an alternative reimbursement CPT code for systems that have conflict with use of 99453 and/or 99454	Billable every 30 days **Note**: This code or 99454 may be used but not both codes for the same member.

Please **click here** to review additional ILOS claims filing instructions under Claims Resources bullet titled "In lieu of services (ILOS) Claim Filing Instructions.

Inpatient Concurrent Care

Each provider from a different specialty/subspecialty can be reimbursed for one initial hospital visit per admission.

Each provider from a different specialty/subspecialty can be reimbursed for a maximum of one subsequent hospital visit per day.

Within the same specialty/subspecialty, only one provider can be reimbursed for an initial hospital visit per admission, and only one provider can be reimbursed for one subsequent hospital visit per day.

Only the provider responsible for discharging the member shall be reimbursed for hospital discharge services on the discharge day.

In all cases, services rendered must meet CPT guidelines and be medically necessary to be eligible for reimbursement.

Inpatient Services

Inpatient services are not reimbursed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services.

Outpatient services (including diagnostic testing) that are related to an inpatient admission and are performed either during or within 24 hours of the inpatient admission, regardless of hospital ownership, are not reimbursed separately as an outpatient service. The inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may bill the outpatient charges on its claim. The only exceptions to this criteria are:

- Outpatient therapy services performed within 24 hours before an inpatient admission or 24 hours after the enrollee's discharge that are either related or unrelated to the inpatient stay; and
- Transfers from a hospital emergency department to a different hospital/provider for inpatient admission.

If either of the above exceptions are met, separate billing and payment for the outpatient hospital service is allowed.

If the enrollee is treated in the emergency room and requires surgery, which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided the enrollee is not admitted as inpatient.

Hospitals are required to bill covered days and their associated ancillary charges. Covered days are days that have been approved through the precertification process.

Hospitals are permitted to bill non-covered days and their associated ancillary charges, but these must be billed separately from covered days and their associated ancillary charges. Non-covered days are days that are not certified or approved.

When an inpatient claim (electronic or paper) is received that includes dates of service that exceed approved days, the entire claim is denied. The provider must resubmit the inpatient claim for covered days only.

For example: If a provider obtains approval for a 10-day stay, and submits a claim for 12 days, the claim must be billed for the 10 **approved days only.** The other **2 non-covered** days would have to be **billed separately**.

Integrated Healthcare Screening

Physical health providers will be reimbursed $15 for each screen completed on a member. The screening may be conducted/performed up to 4 times per calendar year.

Behavioral health providers will be reimbursed $15 for each screen completed on a member. The screening may be conducted/performed up to 2 times per calendar year. An LMHP should be completing this form as part the full bio-psycho-social assessment

Please refer to the **AmeriHealth Caritas Louisianan Provider Handbook** for more details on this value added benefit.

Code	Description	Fee
96160-U1	BH screening performed by a physical health provider, administered to the member (PHQ-9/PSQ).	$15.00
96160-U4	Physical health screening performed by a behavioral health provider, administered to the member (Health & Wellness Questionnaire).	$15.00
96161-U1	BH screening performed by a physical health provider, administered to the member's parent or guardian for the benefit of the member (PHQ-9/PSQ)	$15.00
96161-U4	Physical health screening performed by a behavioral health provider, administered to the member's parent or guardian for the benefit of the member (Health & Wellness Questionnaire).	$15.00

Intrathecal Baclofen Therapy (ITB)

When the implantation procedure is performed in the hospital setting, the hospital is reimbured for the pump in addition to the hospital reimbursement. The cost of the pump is a separate billable item and hospital must use the appropriate HCPCS code and submit the claim on a CMS 1500.

Physicians may bill for the cost of the outpatient bolus injections given to candidates for ITB infusion treatment by submitting the appropriate HCPCS code for each date on which an injection was given.

Only phyisican with specialties in anesthesiology, neurology, nero surgery, or physical medicine rehabilitation may bill for the filling of the reservoir and the maintenancy of the pump.

Locum Tenens Arrangement

The regular physician can submit a claim and receive reimbursement for covered services of a locum tenens physician who is not an employee of the regular physician if:

- The regular physician is unavailable to provide the services.
- The regular physician pays the locum tenens for his or her services on a per diem or similar fee-for-time basis.
- The substitute physician does not provide the services to Medicaid enrollees over a continuous period of longer than 60 days.
- The regular physician identifies the services as substitute physician services by entering HCPCS modifier - Q6 after the procedure code on the claim.

For more details on locum tenens arrangement, please refer to the **AmeriHealth Caritas Louisiana Provider Handbook**.

Long-Acting Reversible Contraceptives (LARC) in the Outpatient Hospital Setting

Reimbursement is made to hospitals for LARC devices when they are inserted during an outpatient hospital visit. Hospitals should bill the DME revenue code of 290 with the appropriate accompanying HCPCS code for the LARC device on the UB-04. Reimbursement for the LARC device in the outpatient hospital setting is in addition to the outpatient hospital reimbursement.

NOTE: Please refer to the Maternity section of this manual for LARCs in the inpatient setting.

LSU Enhanced Professional Service Fees

LSU professional service providers receive an enhanced fee for certain codes. The only codes that are to be paid at these enhanced rates are those specific code and specific type of service combinations that are listed on the **LSU Enhanced Professional Services Fee Schedules**.

If the code and the type of service code are not listed on the enhanced fee schedules, then the minimum rate reimbursed to these LSU providers would be based on the **Louisiana Medicaid Professional Services Fee Schedule**.

Mammography/Mammogram

Hospitals must bill revenue code 403 and the appropriate accompanying CPT codes for screening mammograms.

Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for details on mammography/mammogram coverage criteria.

Maternity

Initial and Follow-up Prenatal Visits

Two initial prenatal visits per pregnancy (270 days) are allowed to be billed. These two visits may not be performed by the same attending provider.

The enrollee needs to be billed as a 'new patient' for each pregnancy whether or not the enrollee is a new or established patient.

The appropriate level E&M CPT procedure code is required to be billed for the initial prenatal visit with the TH modifier. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.

The appropriate level E&M CPT code from the range of procedure codes used for an established patient is required for the subsequent prenatal visit(s). The E&M CPT code for each of these visits must be modified with the **TH** modifier.

The **TH** modifier is required on claims for tobacco cessation counseling within the prenatal period; however, it is not to be used for services in the postpartum period.

If the tobacco cessation counseling is provided as a significant and separately identifiable service on the same day as an E&M visit and is supported by clinical documentation, a modifier to indicate a separate service may be used, when applicable.

The **TH** modifier is **not** required for:

- Observation
- Inpatient hospital physician services
- If the pregnancy is not verified, or if the pregnancy test is negative.

Postpartum Visits

The postpartum care CPT code should be billed for the postpartum care visit and should **not** be billed with "TH" modifier.

Reimbursement is allowed for one postpartum visit per 270 days.

Delivery:

The most appropriate "delivery only" CPT code should be billed by the delivering physician and must include one of the following modifiers in order for the claim to be adjudicated correctly..

Maternity Modifiers:

Modifier	Description
GB	Delivery is **39 weeks or greater**
AT	Delivery is *less than 39 weeks* and medically indicated/spontaneous
GZ	Delivery is *less than 39 weeks* and **NOT** medically indicated
None	Claim denies Z93 – "Correct modifier needed"

Global delivery maternity procedure codes which include antepartum and/or postpartum care should only be billed when the member has primary coverage that includes maternity benefits. It will still require one of the applicable maternity modifiers listed above. If the primary payer is major medical without maternity benefits then a global delivery procedure code should **not** be billed.

Please use the most appropriate revenue code to bill for obstetrics (OB) room and board. Below are important requirements to remember when billing inpatient claims:

- Include the admit or primary delivery diagnosis.
- The secondary diagnosis must be the appropriate outcome of delivery.
- The surgical procedure code for the delivery and the date of the procedure must appear on the claim.
- Authorizations are not required for OB room and board up to 3 days for a standard vaginal delivery and up to 5 days for a Cesarean section delivery. Failure to submit appropriate OB revenue codes will result in claim denials.

Below are the appropriate revenue codes for OB room and board to bill to prevent OB claim denials for no authorization:

Revenue Code	Description	Category
112	**OB OB/PRVT**	Room & Board – Private
122	**OB – OB/2 BED**	Room & Board – Semi-private Two Bed
132	**OB – OB/3 & 4 Beds**	Room & Board – Semi-Private 3 & 4 Bed
152	**OB – OB/Ward**	Room & Board - Ward

Clinical review and authorization is not required of inpatient stays for deliveries when the length of stay is as follows:

Service Description	Labor Days	Requirement
Standard vaginal	2 inpatient	If the delivery occurs on the day after admission, up to **3 days** will be allowed for payment. **Days exceeding this timeframe will require prior authorization.**
Cesarean section	4 inpatient	If the delivery occurs on the day after admission, up to **5 days** will be allowed for payment. **Days exceeding this timeframe will require prior authorization.**

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

Modifier 22 (in addition to the applicable maternity modifier from the list above) for unusual circumstances (i.e., multiple births as mentioned above) 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 cesarean section delivery and a vaginal delivery, the provider must use the most appropriate "delivery only" CPT code for the cesarean section delivery and also bill the most appropriate vaginal "delivery only" procedure code with modifier -51 appended. Both delivery codes must also include the applicable maternity modifier from the list above.

When sterilizations are performed with a delivery and no valid sterilization form was obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization must not be reported on the claim form, and charges related to the sterilization process must not be included on the claim form. Providers will still receive their per diem for delivery covered charges.

When a long-acting reversible contraceptive (LARC) is inserted immediately postpartum and prior to discharge, the LARC device should be billed separate from the inpatient stay, on a CMS 1500 claim form to recieve reimbursement.

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Mother/Newborn/Nursery

Providers are required to bill mother and newborn claims separately. The claim is to include only the mother's room/board and ancillary charges. A separate claim for the newborn must include only nursery and ancillary charges for the baby.

This newborn claim shall be paid at zero as opposed to being denied in order to be counted as a covered service in encounter data (see **exception** below in the **Note**).

When a newborn remains hospitalized after the mother's discharge, the claim must be split billed. The first billing of the newborn claim must be for charges incurred on the dates that the mother was hospitalized.

The second billing must be for the days after the mother's discharge. The newborn assumes the mother's discharge date as his or her admit date.

Note: Well baby per diem rate is payable to facilities that have a published well baby per diem rate. It is only payable when the baby is discharged with mother and baby's stay is not in NICU. If the baby is in NICU it requires an authorization and is payable with the applicable NICU rate if authorized.

Newborn Care and Discharge

Physicians billing for initial newborn care must use the appropriate procedure codes for history and examination of normal newborn when the service meets the criteria for the initial examination rendered. This procedure is limited to one per lifetime of the enrollee.

The procedure code for subsequent hospital care for a normal newborn should be billed per day (other than the discharge date) subsequent to the date of birth. A minimum of three normal newborn subsequent hospital care days are covered.

Circumcision services in the hospital or physician's office setting are billable without an authorization. These services must be billed under the newborn's Medicaid ID.

When the date of discharge is subsequent to the the admission date, the provider should submit claims for newborn hospital discharge services using the appropriate hospital day management code.

When newborns are admitted and discharged on the same date, the provider shall use the appropriate code for these services.

Claims billed with initial/subsequent neonatal and pediatric critical care, and initial and coninuting intensive care services are processed as follows:

- The claims billed with these codes only pay based on provider specialties below:
    - Neonatologist
    - Pediatric Intesivist
- Any other provider specialty that bills this set of codes are not reimbursable

Ultrasounds

A minimum of three obstetric ultrasounds are billable per pregnancy (270 days) without the requirement of a prior authorization or medical review when performed by providers other than maternal fetal medicine specialists.

Obstetric ultrasounds performed while inpatient, in the emergency room and in labor and delivery triage settings are excluded from this count.

For maternal fetal medicine specialists, there is no prior authorization or medical review required for reimbursement of obstetric ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialist.

Midwifery Services

For certified nurse midwives to receive the increased rate for pregnancy and childbirth related services, the modifier UC must be appended to each of the procedure codes listed on the claim form.

Licensed midwives are not required to utilize modifier UC on claim forms.

Certified nurse midwives should not append modifier UC to procedure codes for physician administered injections; long-acting reversible contraceptives (LARC); immunizations; and EPSDTpreventive medical, vision and hearing screenings as these services are reimbursed at 100 percent. Appending modifier UC to these procedure codes will result in a decrease of the reimbursement amount for these services.

Modifiers

The modifiers in the table in this section indicate modifiers that impact reimbursement or policy to establish minimum reimbursement amounts. The below is an exclusive list of modifiers allowed for the purposes of establishing minimum reimbursement rates.

Modifier	Use/Example	Special Billing Instructions	Minimum Reimbursement
22 Unusual Service	Service provided is greater than that which is usually required (e.g., delivery of twins); not to be used with visits or lab codes	Increased Procedural Service Reimbursement Policy	125% of the fee on file or billed charges whichever is lower
24 Unrelated evaluation and management service by the same physician during the post-op period			Lower of billed charges or fee on file
25 Significant, separately identifiable evaluation and management service by the same physician on the		When a suspected condition identified during a screening visit and diagnosed/treated by the screening provider during the same visit, only lower level E&M appended with modifier 25 allowable; otherwise claim will deny	Lower of billed charges or fee on file

same day of a procedure or other service		Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program. Significant-Separately Identifiable Evaluation and Management Service Policy	
26 Professional Component	Professional portion only of a procedure that typically consists of both a professional and a technical component (e.g., interpretation of laboratory or x-ray procedures performed by another provider)	Professional/Technical Components Policy	Lower of billed charges or 40% of the fee on file
TC Technical Component		AmeriHealth Caritas Louisiana does not reimburse the technical component only on laboratory and radiology claims. Reimbursement is not allowed for both the professional component and full service on the same procedure. Professional/Technical Components Policy	
50 Bilateral Procedure		Multiple Procedure Payment Reduction Policy	Lower of billed charges or 150% of the fee on file
51 Multiple Procedures		Multiple Procedure Payment Reduction Policy	Lower of billed charges or 100% of the fee on file for primary/ 50% of the fee on file for all others
52 Reduced Services			Lower of billed charges or 75% of the fee on file
53 Discontinued Procedure	Only for use by Free Standing Birthing Centers (FSBC's) when the enrollee		50% of the FSBC's facility fee or billed charges, whichever is lower

	is transferred prior to delivery		
54 Surgical Care Only	Surgical procedure performed by physician when another physician provides pre- and/or postoperative management		Lower of billed charges or 70% of the fee on file
55 Postoperative Management Only	Postoperative management only when another physician has performed the surgical procedure		Lower of billed charges or 20% of the fee on file
56 Preoperative Management Only	Preoperative management only when another physician has performed the surgical procedure		Lower of billed charges or 10% of the fee on file
NOTE: If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for surgical care only, post-operative care only, or preoperative care only. In order for all providers to be paid in the case when modifiers -54, -55, and -56 would be used, each provider must use the appropriate modifier to indicate the service performed. Claims that are incorrectly billed and paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
57 Evaluation and management service resulting in the initial decision to perform the surgery			Lower of billed charges or fee on file
59 Distinct procedural services performed; separate from other services rendered on the same day by the same provider		Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program. Should not be used for E/M services.	Lower of billed charges or fee on file
XE Separate Encounter		A service that is distinct because it occurred during a separate encounter. Should not be used for E/M services	

XP Separate Practitioner		A service that is distinct because it was performed by a different practitioner. Should not be used for E/M services.	
XS Separate Organ/Structure		A service that is distinct because it was performed on a separate organ/structure. Should not be used for E/M services.	
XU Unusual Non-Overlapping Service		The use of a service that is distinct because it does not overlap usual components of the main service. Should not be used for E/M services.	
62 Two Surgeons		Multiple Procedure Payment Reduction Policy	Lower of billed charges or 80% of the fee on file for each surgeon.
63 Infants less than 4 kg		Increased Procedural Service Reimbursement Policy	Lower of billed charges or 125% of the fee on file
66 Surgical Team	Performance of highly complex procedure requiring the concomitant services of several physicians (e.g., organ transplant)	Documentation must clearly indicate the name of each surgeon and the procedures performed by each. Multiple Procedure Payment Reduction Policy Team Surgery Policy	Lower of billed charges or 80% of the fee on file for each surgeon.
NOTE: In order for correct payment to be made in the case of two surgeons or a surgical team, all providers involved must bill correctly using appropriate modifiers. If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for two surgeons or surgical team. Payment will not be made for any procedure billed for both full service (no modifier) and for two surgeons or surgical team. If even one of the surgeons involved bills with no modifier and is paid, no additional payment will be made to any other surgeon for the same procedure. Claims which are incorrectly billed with no modifier and are paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier			
79 Unrelated procedure or service by the same physician			Lower of billed charges or fee on file

during the postoperative period			
80 Assistant Surgeon (MD)			Lower of billed charges or: MD's - 20% of the full service physician fee on file.
AS Assistant at Surgery (Physician Assistant or APRN)			Lower of billed charges or 80% of MD's 'Assistant Surgeon' fee
NOTE: *The list of codes acceptable with the 80/AS modifier is posted on the Louisiana Medicaid website.			
AT Acute Treatment	Chiropractors use this modifier		Lower of billed charges or fee on file
95	Services provided via a telecommunications system.	Modifier shall be appended to claims for all services provided via telemedicine/telehealth	Lower of billed charges or 100% of the fee on file
Q5 Reciprocal Billing Arrangement	Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group.	The regular physician submits the claim and receives payment for the substitute. The record must identify each service provided by the substitute.	Lower of billed charges or 100% of the fee on file
Q6 Locum Tenens	Services provided by a substitute physician retained to take over a regular physician's practice for reasons such as illness, pregnancy, vacation, or continuing education. The substitute is an independent contractor typically paid on a per diem or fee-for- time basis and does not provide services over a period of longer than 60 days.	The regular physician submits claims and receives payment for the substitute. The record must identify each service provided by the substitute	Lower of billed charges or 100% of the fee on file
TH Prenatal Services			Lower of billed charges or fee for prenatal services

QW Laboratory	Required when billing certain laboratory codes		Lower of billed charges or fee on file

Modifiers-Site Specific

Unless specifically indicated otherwise in CPT, providers should use site-specific modifiers to accurately document the anatomic site where procedures are performed when appropriate for the clinical situation.

E1	Upper left, eyelid Lower left, eyelid	LT*	Left side
E2	Upper right, eyelid	RT*	Right side
E3	Lower right, eyelid	LC	Left circumflex, coronary artery
E4	Left hand, thumb	RC	Right coronary artery
FA	Left hand, second digit	LD	Left anterior descending coronary artery
F1	Left hand, third digit	TA	Left foot, great toe
F2	Left hand, fourth digit	T1	Left foot, second digit
F3	Left hand, fifth digit	T2	Left foot, third digit
F4	Right hand, thumb	T3	Left foot, fourth digit
F5	Right hand, second digit	T4	Left foot, fifth digit
F6	Right hand, third digit	T5	Right foot, great toe
F7	Right hand, fourth digit	T6	Right foot, second digit
F8	Right hand, fifth digit	T7	Right foot, third digit
F9	Upper left, eyelid Lower left, eyelid	T8	Right foot, fourth digit
		T9	Right foot, fifth digit

***** When “bilateral” is part of the procedure code description, **RT/LT or -50 shall not be used.**

Multiple Surgical Reduction Reimbursement

When more than one surgical procedure is submitted for a patient on the same date of service, the 51 modifier is to be appended to the secondary code(s). Certain procedure codes are exempt from this process due to their status as “add-on” or “modifier 51 exempt” codes as defined in CPT. Multiple surgery claims for the same date of service must be billed on one claim form.

Observation

Observation services up to 48 hours are reimbursed without an authorization. Hours exceeding 48, require an authorization. Hours beyond 48 that are not authorized should be denied; however, if hours beyond 48 that are not authorized get paid in error, they are subject to recoupment.

Observation service hours must be billed in units populated in the units field of the UB-04 claim form. The total service hours (units) should be billed using revenue code 762 and the appropriate accompanying HCPCS code(s) G0378 and/or G0379.

In addition to billing the observation service hours, all other associated services including emergency department must be billed on the same claim with the appropriate revenue codes. All covered services are paid separately.

The admission hour and discharge hour must also be included on the claim.

Outpatient surgical procedures provided on the same day as observation are not reimbursed.

Opioid Treatment Programs (OTP)

Reimbursement for members receiving methadone treatment in an Opioid Treatment Program (OTP) consists of a daily bundled rate. The bundled rate is inclusive of all services provided in the OTP including, but not limited to:

- Medication: This includes the administration, dosing, and dispensing of methadone as per the patient's treatment plan.
- Counseling: Patients are required to participate in group or individual sessions as part of the patient's treatment plan.
- Urine Drug Testing: This includes the urine drug testing or other laboratory tests deemed medically necessary.
- Physical examinations by a physician, advanced practice registered nurse, or physician assistant.
- Evaluation and management visits.
- Case management.
- Laboratory services.

Providers shall not bill separately for any services provided in the OTP. There is a limit of one daily bundled rate per patient per day of service. Guest dosing shall be billed by the guest facility and not the home facility. For claim submission, the billing provider number shall also be used as the rendering provider.

The HCPCS code for the daily methadone treatment bundle is H0020. On days of service where a patient is receiving a take-home dose, providers shall append the modifier U8.

Example 1: A patient is starting treatment and attends the OTP six days per week with a take-home dose for Sunday when the clinic is closed.

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Code	H0020	H0020	H0020	H0020	H0020	H0020	H0020-U8

Example 2: A patient attends the OTP on Monday, Wednesday, and Friday, and receives four take-home doses weekly.

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Code	H0020	H0020-U8	H0020	H0020-U8	H0020	H0020-U8	H0020-U8

Example 3: A patient attends the OTP once every two weeks and receives 13 take-home doses.

Week 1:

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Code	H0020	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8

Week 2:

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Code	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8

Billing for members receiving buprenorphine treatment in an Opioid Treatment Program (OTP) consists of two components: the daily bundle rate for clinical care (H0047) and the ingredient cost of the medication (J-codes).

Code	Description	Unit
H0047	Alcohol and/or drug services - NOS (buprenorphine service)	Day
J0571	Buprenorphine, oral, 1 mg	1 mg
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	Per Dose
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	Per Dose
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	Per Dose
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	Per Dose

J-code/NDC Billing Instructions

Federal law requires that any code for a drug covered by Medicaid (billed using the appropriate J-code) must be submitted with the 11-digit NDC assigned to each drug package. The NDC specifically identifies the manufacturer, product and package size. Each NDC is an 11-digit number, sometimes including dashes in the format 55555-4444-22. When submitting claims, providers are to submit each NDC using the 11-digit NDC without dashes or spaces. The NDC included on the claim must be the exact NDC that is on the package used by the provider.

Some drug packages include a 10-digit NDC. In this case, the provider should convert the 10 digits to 11 digits when reporting this on the claim. When converting a 10-digit NDC to an 11-digit NDC, a leading zero should be added to only one segment:

- If the first segment contains only four digits, add a leading zero to the segment;
- If the second segment contains only three digits, add a leading zero to the segment;
- If the third segment contains only one digit, add a leading zero to the segment.

The NDC is required at the detail level when a claim is submitted with a J-code. In addition to the NDC number, providers must indicate the NDC units. NDC units are based upon the numeric quantity administered and the unit of measurement. "EA" (each) is used when the product is dispensed in discreet units such as films or tablets.

The Louisiana Single Preferred Drug List is located at:

https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Non-preferred forms of buprenorphine and buprenorphine/naloxone require prior authorization.

Dosage Billing Guide

Buprenorphine (without naloxone) is priced per milligram. Providers bill the number of units equivalent to the number of milligrams dispensed.

For buprenorphine/naloxone, while the J-code descriptions state a range, the fee is based on a specific strength, according to the table below.

Code	Description	Priced to equal	Unit
J0571	Buprenorphine, oral, 1 mg	Per 1mg	Per mg
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	1x2mg/0.5mg film	Per Dose
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	1x4mg/1mg film	Per Dose
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	1x8mg/2mg film	Per Dose
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	1x12mg/3mg film	Per Dose

Providers are expected to bill the dosage which most closely matches the dose administered. Billing multiple units of smaller dosages or other combinations of J-codes to maximize reimbursement is prohibited and may be subject to recoupment.

For dosages not represented above, the following combinations of J-codes are to be billed:

Total Target Dose	Code	Description	Units
16mg/4mg	J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	2
20mg/5mg	J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	1
	J0575	Buprenorphine/naloxone, oral, greater than 10 mg	1
24mg/6mg	J0575	Buprenorphine/naloxone, oral, greater than 10 mg	2

For example, for a total target dose of 16mg/4mg on a day of service (row number one), the provider must bill two units of J0574. Each unit represents one 8mg/2mg film or tablet. The corresponding NDC of the film or tablet must also be submitted with the claim.

Dosages above 24mg of buprenorphine (with or without the naloxone component) are not payable in Louisiana Medicaid.

Modifiers

For take-home doses of buprenorphine, the following modifiers must be applied:

Code	Description	Modifier
H0047	Alcohol and/or drug services - NOS (buprenorphine service)	U8
J0571	Buprenorphine, oral, 1 mg	RD
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	RD
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	RD
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	RD
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	RD

Daily Unit Limits

On any given day of service, providers may not bill more than the number of units listed below.

Code	Description	Unit	Daily Limit
J0571	Buprenorphine, oral, 1 mg	Per mg	24
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	Per Dose	1
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	Per Dose	1
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	Per Dose	2
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	Per Dose	2

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. Drugs are required to be billed with NDC information (valid NDC, NDC units and NDC unit of measure). Outpatient hospital clinic services must be billed with revenue codes 510, 514, 515, 517 and 519 and the appropriate accompanying CPT codes of 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214 and 99215.

Outpatient rehabilitation evaluation codes below are limited to one per 180 days:

Description	CPT/HCPCS
Evaluation of Speech Fluency	92521
Evaluation of Speech Production	92522
Speech Sound Lang Comprehension	92523

Behavioral Quality Analysis Voice	92524
Physical Therapy Evaluation: Low Comp	97161
Physical Therapy Evaluation: Mod Comp	97162
Physical Therapy Evaluation: High Comp	97163
Occupational Therapy Evaluation: Low Comp	97165
Occupational Therapy Evaluation: Mod Comp	97166
Occupational Therapy Evaluation: High Comp	97167

CPT codes 97110 and 97530 may be billed with either physical therapy revenue codes or occupational therapy revenue codes to best reflect the specific scope of services provided.

Physician Administered Drugs

Administration of a covered drug by a physician may be billed using the lowest level office visit (CPT procedure code 99211) if a higher-level evaluation and management visit has not been submitted for that date by the rendering provider. Any alternative reimbursement fordrug administration must be equivalent to or greater than the reimbursement for CPT code 99211

Physician Assistant

Physician assistant services are to be billed on the CMS 1500 or 837p claim forms.

Services provided by the physician assistant must be identified by entering the specific physician assistant provider number in field 24J on the claim form. The group number must be entered in field 33.

Physicians who employ or contract with physician assistants must have a group provider number and must link the physician assistant's individual provider number to the group. Physician groups must notify AmeriHealth Caritas Louisiana when physician assistants are added or removed from the group.

Physician assistants who **perform** as **assistant at surgery** must use the **"AS"** modifier to identify these services.

NOTE: Services rendered by the physician assistant billed and paid by AmeriHealth Caritas Louisiana using a physician's number as the attending provider are subject to post payment review and recovery

Policy For Papanicolaou (PAP) Test / Cervical Cancer Screenings

Based on American College of Obstetricians and Gynecologists (ACOG) guidelines regarding Papanicolaou testing (Pap tests), a routine test is not covered for enrollees under 21 years of age, with some exceptions:

- As a value added service, AmeriHealth Caritas Louisiana will cover Pap tests (or cervical cancer screenings) for pregnant members under 21 regardless of ACOG criteria. The claim must be submitted with a pregnancy diagnosis (O00.XX-O99.XX) or it will deny.

Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for more Pap test exceptions/ coverage details on enrollees under 21.

Portable Oxygen

Providers are reimbursed the rate on file for the date of service for each authorized unit within a month. Only 1 unit per HCPCS code for portable oxygen contents is allowed per claim line regardless of the date(s) of service. Multiple claim lines for the HCPCS code for portable oxygen may be billed for the same dates of service.

Portable X-Ray Services

Technical components of these services are not reimbursed as a separate part of the service. Providers billing for these services must bill a full component only.

Preventive Service (Adult)

When submitting claims for preventive medicine E/M services, providers must use the appropriate Preventive Medicine Services "New Patient" or "Established Patient" CPT code based on the age of the enrollee when submitting claims for the services .

Preventive medicine E/M services are comprehensive in nature and must reflect age and gender specific services.

If an abnormality or pre-existing problem is encountered and treatment is significant enough to require additional work to perform the key components of a problem-oriented E&M service on the same date of service by the provider performing the preventive medicine service visit, an additional office visit of a higher level than CPT code 99212 is not covered and should not be billed.

Proprietary Laboratory Analyses (PLA) Testing

PLA codes must be used with the specific device or kit. "Services should not be reported with any other CPT code and other CPT codes should not be used to report services that may be reported with that specific PLA code."

The expectation is that the procedure codes are billed in accordance with CPT guidelines.

Effective May 1, 2024, billing of the CPT PLA codes 0202U, 0223U, 0224U, 0225U, 0226U, 0240U and 0241U will be limited solely to services performed in a (UB-04) facility, observation and/or inpatient setting. These procedure codes may no longer be billed in an outpatient setting as such they have been removed from the Louisiana Medicaid Laboratory and Radiology Fee Schedule.

Radiation Oncology Therapies

Effective July 1, 2024, CPT code **77387-Guidance for localization of target volume for delivery of radiation treatment, includes intrfraction tracking, when performed** is no longer covered**.**

Providers should instead utilize the following HCPCS codes as appropriate:

HCPCS Code	Description
G6001	Ultrasonic guidance for placement of radiation therapy fields
G6002	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy

These codes can also be used to report the professional component of services by appending the -26 modifier to the codes.

Rapid Whole Genome Sequencing of Critically Ill Infants

Rapid whole genome testing is reimbursed separately from the hospital reimbursement for inpatient services. The minimum reimbursement for rapid whole genome sequencing (including reimbursement for individual sequencing, trio sequencing of the parents of the infant, and ultra-rapid sequencing) is equal to the fees on the Louisiana Medicaid Laboratory and Radiology (Non-Hospital) Fee Schedule in addition to the minimum per diem as published in the Louisiana Medicaid Inpatient Hospital Per Diem Fee Schedule.

Hospitals must bill the rapid whole genome sequencing claim using the appropriate CPT code on a CMS 1500 claim form. If the hospital bills electronically, the 837P must be used.

Same-Day Outpatient Visits

Enrollees under Age 21

When medically necessary, two same-day outpatient visits per specialty per enrollee are allowed; however, the second same-day outpatient visit is payable for only the two lowest level Evaluation and Management (E/M) codes.

If an EPSDT screening has been paid, only the two lowest level E/M codes are payable for the same enrollee on the same date of service and by the same attending provider. In these circumstances, when it is clinically appropriate, providers may use the correct modifier to allow both services to be covered.

A same day follow up office visit for the purpose of fitting eyeglasses is allowed, but no higher level office visit than the lowest level E/M code is reimbursable for the fitting. Appropriate modifier usage may be required.

Enrollees Age 21 and Over

If a preventive medicine E/M service has been paid, only the two lowest level E/M codes are reimbursable for the same enrollee, on the same date of service, and by the same attending provider.

Secondary Bilateral Surgical Procedures

Multiple modifiers may be appended to secondary surgical procedure codes when appropriate. Billing multiple surgical procedures and bilateral procedures during the same surgical session should follow Medicaid policy for each type of modifier and must be billed on one claim form.

Bilateral secondary procedures are submitted with modifiers 50/51 and at a minimum be reimbursed at 75% of the Medicaid allowable fee or the submitted charges, whichever is lowest.

When "bilateral" is part of the procedure code description, **RT/LT or -50 shall not be used.**

Please refer to AmeriHealth Caritas Louisiana Bilateral Procedures reimbursement policy for additional details.

Sterilization

The sterilization consent form or a physician's written certification must be obtained before providers may be reimbursed. The surgeon must submit the claim with the consent form or written certification attached and is expected to share copies of the completed consent form or written certification with ancillary providers. Ancillary providers include the assistant surgeon, anesthesiologists, hospital, and/or ambulatory surgical center may submit claims without the consent form. However, providers may only be reimbursed if the surgeon submitted a valid sterilization consent and was reimbursed for the procedure.

The ancillary provider's claim may be held for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, the claim will deny. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim with the appropriate consent form.

When submitting claims for services requiring a sterilization consent form, the enrollee's name on the Medicaid file for the date of service must be the same as the name signed at the time of consent. If the enrollee's name is different, the provider must attach a letter from the provider's office from which the consent was obtained. The letter must be signed by the physician and must state the enrollee's name has changed and must include the enrollee's social security number and date of birth.

The informed consent must be obtained and documented prior to the performance of the sterilization.

Errors in the following sections can be corrected, but only by the person over whose signature they appear:

- "Consent to Sterilization,"
- "Interpreter's Statement,"
- "Statement of Person Obtaining Consent," and
- "Physician's Statement".

If either the enrollee, the interpreter, or the person obtaining consent returns to the office to make a correction to his/her portion of the consent form, the medical record must reflect his/her presence in the office on the day of the correction.

To make an allowable correction to the form, the individual making the correction must line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, "write-overs," or use of correction fluid in making corrections are unacceptable.

Only the enrollee can correct the date to the right of their signature. The same applies to the interpreter, to the person obtaining consent, and to the doctor. The corrections of the enrollee, the interpreter, and the person obtaining consent must be made before the claim is submitted.

The date of the sterilization may be corrected either before or after submission by the doctor over whose signature it appears. However, the operative report must support the corrected date.

Substance Use Disorder (SUD) Pregnant and Post-Partum

Effective for dates of service between **October 1, 2024 and June 30, 2025** claims billed with SUD HCPCS codes for pregnant or post-partum enrollees must be appended with a **TH** modifier for claims to be reimbursed with the correct rates.

Substitute Physician Billing

The enrollee's regular physician may submit the claim for a substitutue physician and receive reimbursement for covered services which the regular physician arranges to be provided by the substitute physician on an occasional reciprocal basis if:

- The regular physician is unavailable to provide the services.
- The substitute physician does not provide the services to Medicaid enrollees over a continuous period of longer than 60 days. Please refer to the **AmeriHealth Caritas Louisiana Provider Handbook** for details on the continuous period.

The regular physician identifies the services as substitute physician services by entering the HCPCS modifier - **Q5** after the procedure code on the claim. By entering the **-Q5** modifier, the regular physician (or billing group) is certifying that the services billed are covered services furnished by the substitute physician for which the regular physician is entitled to submit Medicaid claims.

If the regular physician does not come back after the 60 days, the substitute physician must bill for the services under his/her own Medicaid provider number.

This situation does not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified.

Telehealth Claims

Any services provided (physical or behavioral health) using telehealth must be identified on claims submission by appending the modifier 95 to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement.

Please refer to AmeriHealth Caritas Louisiana Telehealth reimbursement policy for more details.

Third Party Liability (TPL) Claims

A copy of the explanation of benefits (EOB) from all third party insurers must be submitted with the original claim form **except** for the following services listed below. These services are typically not reimbursed by commercial health plans and are accepted without an explanation of benefits (EOB).

- H0018-Therapeutic Group Home
- H0039-Assertive Community Treatment per diem
- H0045-Crisis Stabilization
- H2017-Psychosocial Rehabilitation Services
- H0036-Community psychiatric support and treatment
- H2033-Multi-systemic Therapy
- H2011-Crisis Intervention Service, per 15 minutes
- S9485-Crisis Intervention Mental Health Services
- T1019- EPSDT Personal Care Services (PCS)
- T1025, T1026, T2002-Pediatric Day Health Care

Another **exception to the EOB requirement** is Preventive Pediatric Care (PPC), including EPSDT, EPSDT referral and when well-baby procedure codes 99460, 99462, and 99238 are billed with diagnosis codes Z38 through Z38.8.

For enrollees that have Medicare and Medicaid (dual eligible) the following codes are eligible for **Medicare EOB** bypass:

Code	Description
H0001	Alcohol and/or drug assessment (unlicensed individual under supervision of a licensed clinician) **with a modifier for degree level**
H0004	Behavioral health counseling and therapy, unlicensed (unlicensed individual under supervision of a licensed clinician) **with a modifier for degree level**
H0005	Addiction - alcohol and/or drug services, group counseling by a clinician (unlicensed individual under supervision of a licensed clinician) **with a modifier for degree level**
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) (adult only Level III.7D)
H0012	Alcohol and/or drug abuse service; sub-acute detoxification (residential addiction program outpatient) (Level III.2D)
H0014	Alcohol and/or drug treatment, ambulatory detox
H0015	Alcohol and/or drug services, intensive outpatient (treatment program that operates at least three hours per day and at least three days per week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention and activity therapies or education (licensed and unlicensed individual under supervision of a licensed clinician) **with a modifier for degree level** (Level II.1)
H0018	Therapeutic group home
H0019	Addiction - behavioral health, long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem (adult only Level III.3)
H0036	Community psychiatric support and treatment
H0038	Peer support services
H0039	Assertive community treatment, per diem
H0045	Crisis stabilization
H0049	Addiction - alcohol and/or drug screening
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
H2011	Mobile crisis response
H2011	Community brief crisis support
H2013	Psychiatric health facility service, per diem (specialized)
H2017	Psychosocial rehabilitation
H2022	Psychosocial rehabilitation for VOA North Louisiana
H2024	Individual placement and support
H2033	Multisystemic therapy

H2034	Alcohol and/or drug abuse, halfway house services, per diem (Level III.1)
H2036	Alcohol and/or drug treatment program, per diem (Level III.5)
S5125	Personal care services
S5126	Personal care services - per diem
S9484	Behavioral health crisis care
S9485	Rehab. Crisis intervention - per diem
S9485	Mobile crisis response
S9485	Behavioral health crisis care - per diem

Also, for dual eligible enrollees incurring services of a **Licensed Addiction Counselor (LAC),** claims do not require a Medicare EOB because Medicare does not enroll LACs. The services must be appended with modifier HF.

Standard coordination of benefits cost avoidance for prenatal services, labor and delivery, and postpartum care are applied as referenced in Informational Bulletin 21-7: Bipartisan Budget Act of 2018.

A "wait and see" period policy is followed on claims for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.

- "Wait and see" is defined as payment of a claim only after documentation is submitted demonstrating that 100 days have elapsed since the provider billed the responsible third party and remains to be paid. The Wait and See Period Attestation Form is located on the AmeriHealth Caritas Louisiana website under the Forms section.

- The claim must be submitted with a completed Wait and See Period Attestation Form in order to be considered for payment.

  Submit claims to the following address:

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

- The provider can only bill for the balance not paid by the liable third party and payment can only be made for up to the Medicaid allowable amount.

Vagus Nerve Stimulators

(VNS)

HCPCS procedure codes C1767 (VNS generator) and/or C1778 (VNS leads) should be billed to be reimbursed on the prior authorized VNS.

Vision

Medical records should be included with the claim for the following vision services codes. Claims submitted without medical records are denied.

- V2199- Not Otherwise Classified, Single Vision Lens
- V2220- Specialty Bifocal (By Report)
- V2399- Specialty Trifocal (By Report)
- V2499- Variable Asphericity Lens, Other Type
- V2599- Contact Lens, Other Type, Per Lens
- V2799-Vision Services Miscellaneous
- V2102-Sphere, Single Vision, Plus or Minus
    - Must include applicable modifier when the procedure code lens is over 12.00 D spheres
        - RT- Indicates right eye
        - LT –Indicates left eye
    - Documentation of sphere is required

Claims for "fitting of spectacles" (CPT codes 92340-92342) may be reimbursed separately on the same day or subsequent day as an optometrist or ophtalmalogist office visit.

Reimbursement covers delivery and final adjustment to the visual axis and anatomical topography of covered eyewear. If final adjustments to the visual axes and anatomical topography are **not** performed during the member's return, the provider must **not** bill for the "fitting of spectacles." For example, if the member returns to the office only to pick up eyewear, billing of the procedure code for fitting of spectacles is considered inappropriate billing.

HCPCS code S0580 for polycarbonate lens should no longer be billed and HCPCS code V2784 should be used instead.

Vitamin D Testing

Only one Vitamin D test per date of service is covered, and no more than four tests per span of twelve months is allowed.

Vitamin D testing must be reported with CPT code(s) 82652 or 82306 and is reimbursable with a medical condition that indicates the patient either shows signs and/or symptoms of vitamin D deficiency or is at risk of vitamin D deficiency.

Please refer to AmeriHealth Caritas Louisiana Vitamin D Testing reimbursement policy for more details.

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically…	Contact Optum/Change Healthcare at: 877-363-3666 or Availity at 800-282-4548
If you have general EDI questions…	Contact AmeriHealth Caritas Louisiana EDI Technical Support at: 866-428-7419 or by e-mail at: edi@amerihealthcaritasla.com
If you have questions about specific claims transmissions or Acceptance and Claim Status reports…	Contact your EDI Software Vendor or • call the Optum/Change Healthcare Provider Support Line at 800-845-6592 • or Availity at 800-282-4548
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)…	Contact Provider Claim Services at 888-922-0007
If you have questions about claims that are reported on the Remittance Advice…	Contact Provider Claim Services at 888-922-0007
If you need to know your provider NPI number…	Contact Provider Services at: 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 using the Provider Change form located at: www.amerihealthcaritasla.com/provider/resources/forms/index.aspx Fax: 225-300-9126; Provider Services: 888-922-0007
If you would like information on the 835 Remittance Advice…	Contact your EDI Vendor or • call Optum/Change Healthcare at 877-363-3666 • or Availity at 800-282-4548
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: 888-482-8057
Sign up for Electronic Funds Transfer	Contact Optum/Change Healthcare at 866-506-2830 or Availity at 800-282-4548

NOTES