MedStar Family Choice

Claims Billing Manual

November 2023

MedStar Family Choice

Claims Billing Manual Objective

The objective of this manual is to provide a general overview and serve as a reference guide for healthcare providers who participate in the MedStar Family Choice District of Columbia (DC) and/or MedStar Family Choice Maryland Medicaid Program(s).

Please be advised that this is not intended to be a comprehensive documentation of policies and procedures. The procedures in this manual include specific instructions to file claims for reimbursement.

Providers are responsible for adhering to the requirements set forth in this manual and other policies and procedures indicated on the MedStar Family Choice Provider websites.

Claims Billing Manual General Overview

The purpose of this Manual is to provide guidance for billing Electronic and Paper claims for both professional and Institutional healthcare services rendered.

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Completing the CMS Claim Forms

The Center for Medicaid and Medicare Services (CMS) mandates the use of the Health Insurance Claim Form (CMS-1500 Claim Form & UB-04). To be reimbursed for services rendered on behalf of MedStar Family Choice Medicaid beneficiaries, clinics, DME suppliers must complete and file a CMS-1500 Claim Form.

These instructions describe the information that must be entered in the minimum required fields of the CMS-1500 Claim Form or UB-04 claim form(s). The following instructions outline specifically the use of the form when billing for clinic related or Facility services.

The **CMS-1500 Claim Form -** Form must be completed for all professional medical services, and the **UB-04 claim** form must be completed for all facility claims. All claims must be submitted within the required filing deadline of 365 days from the date of service in the D.C. and 180 Days in Maryland. The following examples of claim filing requirements refer to both paper and electronic submissions.

The following claim forms are approved for filing claims utilizing the national standards for claim completion for goods or services provided to Medicaid beneficiaries:

- CMS - 1500 Claim Form
- UB-04

MedStar Family Choice encourages transmission of electronic claims (EDI). MedStar Family Choice uses Change Healthcare as their clearinghouse. MedStar Family Choice payor IDs are as follows:

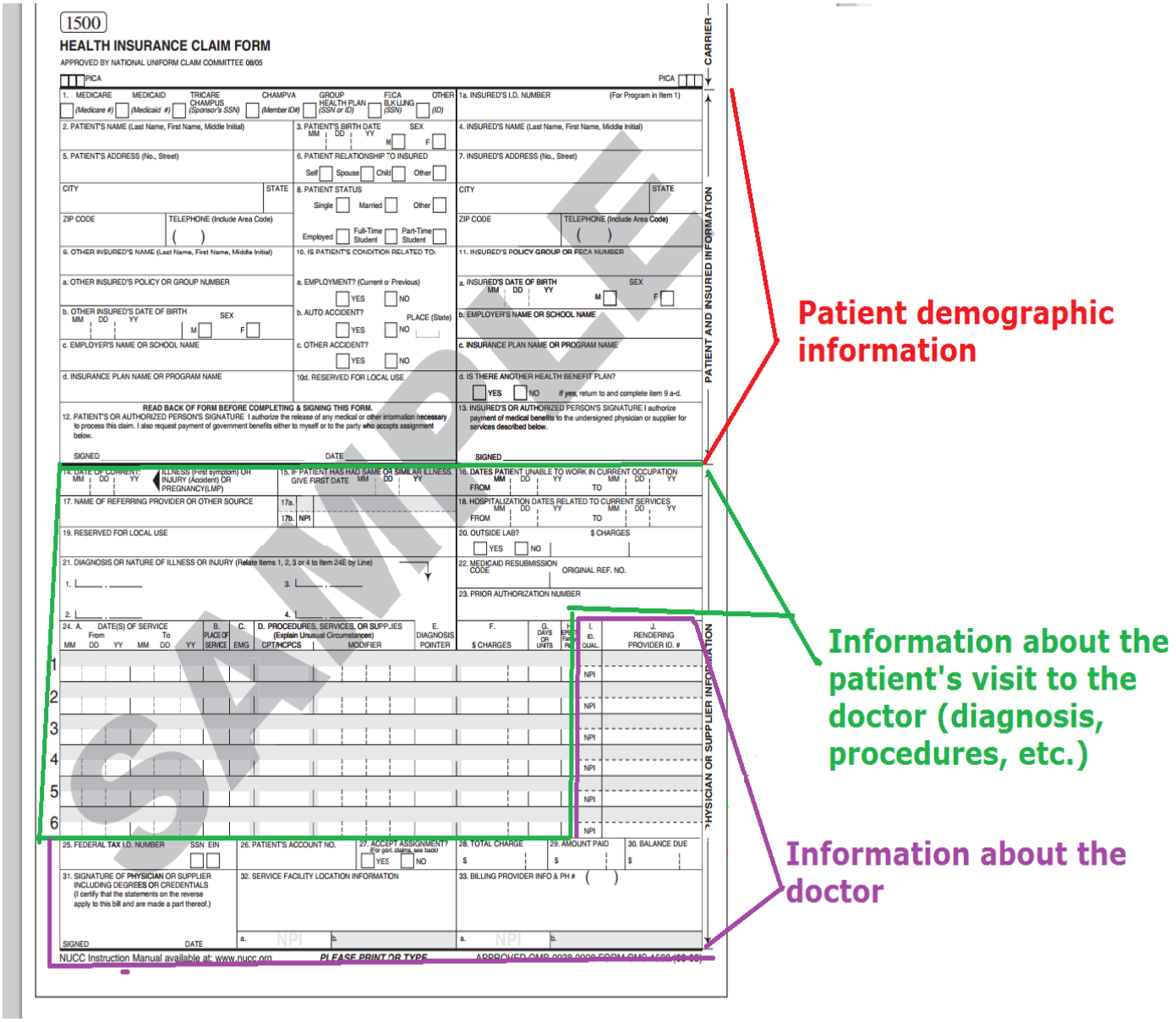
DC: RP062
Maryland: RP063

Note: All paper CMS - 1500 Claim Form and UB04 claims must be submitted on the original red and white claim form. Red claims forms may be purchased from any office supply store or the Government Printing Office. Black and white versions of the claim forms will not be accepted and will be returned to the providers with a request to resubmit on the proper claim form.

Submit claims to the Plan at the following address (DC and Maryland):

MedStar Family Choice Claims Processing Center
P.O Box 211702
Eagan, MN 55121

CMS - 1500 Claim Form Reference Sheet Snapshot – by section.



Patient Demographics – Identifying data such as Name, date of birth, address, and Insurance information used to stremline the medical billing process.

Visit Information – Information specific to visit such as date(s) of service (diagnosis code, procedure code, Modifier)

Provider Information – Data to identify health professional, organization, or group that rendered healthcare services.

Table 5: CMS - 1500 Claim Form Instructions (paper)

Field #	Field Description	Guideline
1	**Health Insurance Box**	Select Medicaid
1a	**Insured's ID Number**	Enter the patients' DC or MD Medical Assistance # or MFC ID# identification excluding the leading zeroes. • Verify the beneficiary's Medical Assistance ID# • Validate beneficiary's DC or MD Medicaid Identification number. • Ensure beneficiary is eligible for the services. Call the Interactive Voice Response (IVR) system or visit www.dc-medicaid.com to verify eligibility for beneficiary or https://encrypt.emdhealthchoice.org/emedicaid/. Receipt of a prior authorization doesn't verify beneficiary eligibility.
2	**Patient's Name**	Enter the patients last name, first name, and middle as it appears on their Medicaid/ID Card
3	**Patient's Date of Birth**	Enter the patient's date of birth and select the appropriate gender
4	**Insured's Name (Last Name, First Name, Middle initial)**	Not required for processing
5	**Patient's address**	Not required for processing
6	**Patient's Relationship to Insured**	Not required for processing
7	**Insured's Address**	Not required for processing
8	**Reserved For NUCC Use**	Not required for processing
9	**Other Insured's Name**	If patient has other health insurance coverage, enter the name of the policy holder in last name, first name, middle initial format
9a	**Other Insured's Policy or Group Number**	Enter policy Number
9b	**Reserved for NUCC Use**	Not required for processing
9c	**Reserved For NUCC Use**	Not required for processing
9d	**Insurance Plan Name or Program Name**	Name of the Plan or Program
10	**Is Patient 's Condition related to:**	
10a	**Employment (current or Previous**	Select appropriate box to indicate patient's condition

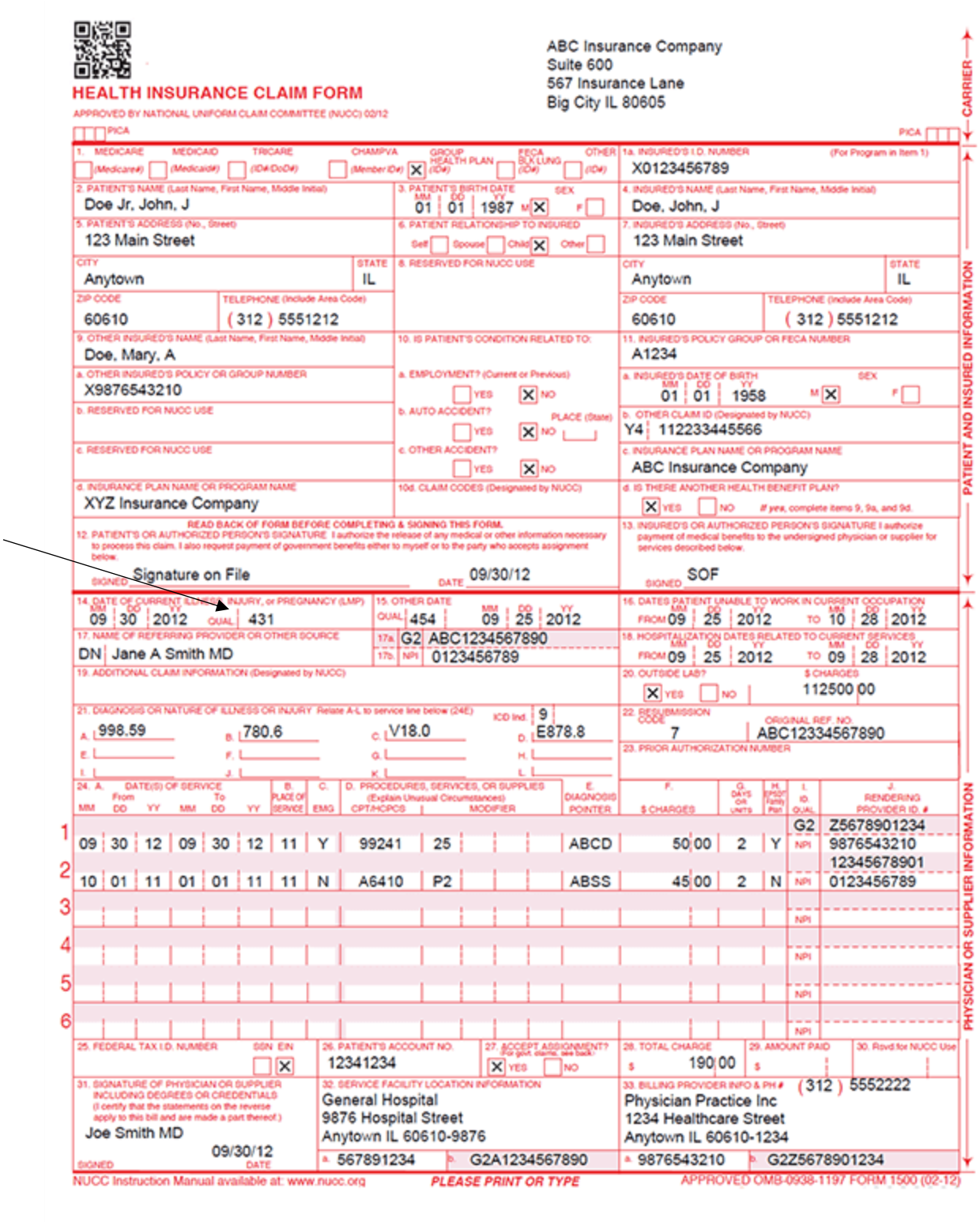
Field #	Field Description	Guideline
10b	**Auto Accident**	Select the appropriate box to indicate if the patient's condition is related to auto accident
10c	**Other Accident**	Select the appropriate box to indicate if the patient's condition is related to a different type of accident
10d	**Claim Codes**	Not required for processing
11	**Insured Policy Group or FECA No**	Enter the policy group or FECA Number
11a	**Insured's Date of Birth and Sex**	Not required for processing
11b	**Other Claim ID**	Not required for processing
11c	**Insured Plan Name or Program Name**	Enter the name of the insurance company or program name
11d	**Is there Health Plan**	Select the appropriate box
12	**Patient's Signature**	Enter the signature or "Signature on file" and include the date in MMDDYY format
13	**Insured's or Authorized Person's Signature**	Not required for processing
14	**Date of Current Illness**	Not required for processing
15	**Other Date**	Not required for processing
16	**Dates Patient Unable to Work in Current Occupation**	Not required for processing
17	**Name of Referring Provider or other Source**	Enter the name (First Name, Middle Initial, Last Name) of the referring provider, if applicable.
17a	**Identification #**	If using NPI in field 17b, enter the taxonomy code in 17a and the qualifier "ZZ" in the box to the left.
17b	**NPI #**	Enter the referring provider's NPI.
18	**Hospitalization Dates Related to Current Services**	Enter the admission/discharge dates in MMDDYY format if the services are related to hospitalization
19	**Additional Claim Information**	When billing for waiver services, enter "03" special program code.
20	**Outside Lab? $ Charges**	Not required for processing
21	**Diagnosis or Nature of Illness or Injury**	• Enter the ICD-10 Codes in the ICD diagnosis indicator to identify version of ICD codes being reported. • Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. • Enter the appropriate numeric diagnosis code.
22	**Resubmission Code or Original Ref. Number**	Not required for processing***//Must enter 7 with claim# for corrected*** **and** ***8 with claim # for Voided***
23	**Prior Authorization Number**	Enter the 10-digit prior authorization number if applicable

Field#	Field Description	Guideline
24A	**Shaded area**	Enter the NDC qualifier “N4” and the 11-digit NDC number in the shaded (top portion) of field 24 for physician administered drugs, if applicable. Include the NDC unit of measure (two digit) and the NDC units. NDC units must be converted to the corresponding HCPCS/CPT code units accurately.
24A	**Date(s) of Service**	Enter the FROM and TO date of the service(s) in MMDDYY format.
24B	**Place of Service**	For each line, enter the code that best describes the place of service: 01 Pharmacy 02 Telehealth 03 School 04 Homeless Shelter 05 HIS Free-Standing Facility 06 HIS Provider-Based Facility 07 Tribal 638 Free-Standing Facility 08 Tribal 638 Provider-Based Facility 09 Prison 10 Telehealth Provided in Patient's Home 11 Office 12 Home 13 Assisted Living Facility 14 Group Home 15 Mobile Unit 16 Temporary Lodging 17 Walk-in retail Clinic 18 Worksite 19 Off Campus Outpatient Hospital 20 Urgent Care 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance Land 42 Ambulance Air or Water

Field#	Field Description	Guideline
24B	**Place of Service**	49 Independent Clinic 50 FQHC 51 Inpatient Psychiatric Facility 52 Psych Facility Partial Hospital 53 Community Health Center 54 Intermediate Care Facility 55 Residential Substance Abuse Treatment Center 56 Psychiatric Resident Treatment Center 57 Non- Resident Substance Abuse 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End State Renal Disease Treatment Facility 71 State Local Public Health Clinic 72 Rural Health 81 Independent Laboratory 99 Other
24C	**EMG**	Not required for processing
24D	**Procedures, Services, or Supplies**	Enter CPT or HCPCS code(s) and modifier (if applicable)
24E	**Diagnosis Pointer**	Enter the diagnosis code reference letter (pointer) as shown in item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters are applicable. ICD codes must be entered in Item Number 21 only. Do not enter them in 24E. Enter letters left justified in the field. Do not use commas.
24F	**$ Charges**	Enter the usual and customary charges of the services billed, right justified. Enter "00" in the cents area if the amount is a whole number.
24G	**Days or units**	Enter the number of days or units.
24H	**EPSDT Family Plan.**	Not required for processing
24I	**ID Qualifier (shaded area)**	If using NPI in field 24J, enter the qualifier "ZZ". If using a DC Medicaid provider ID for an atypical provider, enter the qualifier "1D".
24J	**Rendering Provider ID (shaded area)**	Enter the taxonomy code of servicing provider if NPI was entered in 24J (white area); otherwise, enter the DC Medicaid provider ID if an atypical provider.

Field#	Field Description	Guideline
24J	**NPI**	Enter the rendering provider's NPI
25	**Federal Tax ID Number**	Enter the appropriate social security number or employer identification number.
26	**Patient's Account Number**	Not required for processing
27	**Accept Assignment**	Not required for processing
28	**Total Charge**	Enter the total of column 24F.
29	**Amount Paid**	Enter the amount received from other healthcare plan
30	**RSVD for NUCC Use**	
31	**Signature of Physician or Supplier**	Must have an original signature and date
32	**Service Facility Location Information**	Not required for processing
32a	**NPI**	Not required for processing
32b	**Other ID**	Not required for processing
33	**Billing Provider Info & Phone#**	Enter the billing address for the pay-to-provider and include Zip code +4
33a	**Billing NPI**	Enter the pay-to provider's NPI Number
33b	**Billing Provider**	If using NPI in field 33a, enter the taxonomy code in 33b and the qualifier “ZZ” in the box to the left. If using a DC Medicaid provider ID for an atypical provider, enter the DC Medicaid provider ID in field 33a and the qualifier.

CMS - 1500 Claim Form Completed Example:



HEALTH INSURANCE CLAIM FORM

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

ABC Insurance Company
Suite 600
567 Insurance Lane
Big City IL 80605

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): X0123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe Jr, John, J

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1987 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John, J

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Main Street

CITY: Anytown STATE: IL

8. RESERVED FOR NUCC USE

CITY: Anytown STATE: IL

ZIP CODE: 60610 TELEPHONE (Include Area Code): (312) 5551212

ZIP CODE: 60610 TELEPHONE (Include Area Code): (312) 5551212

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Mary, A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: A1234

a. OTHER INSURED'S POLICY OR GROUP NUMBER: X9876543210

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 01 01 1958 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): Y4 112233445566

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC Insurance Company

d. INSURANCE PLAN NAME OR PROGRAM NAME: XYZ Insurance Company

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] 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: Signature on File DATE: 09/30/12

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: SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 30 2012 QUAL: 431

15. OTHER DATE QUAL: 454 MM DD YY: 09 25 2012

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 09 25 2012 TO 10 28 2012

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Jane A Smith MD

17a. G2 ABC1234567890

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 09 25 2012 TO 09 28 2012

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 112500 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9
A. 998.59 B. 780.6 C. V18.0 D. E878.8
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 7 ORIGINAL REF. NO.: ABC12334567890

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 09 30 12	09 30 12	11	Y	99241	25	ABCD	50 00	2	Y	G2	Z5678901234
										NPI	9876543210
2 10 01 11	01 01 11	11	N	A6410	P2	ABSS	45 00	2	N	NPI	12345678901
										NPI	0123456789
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 12341234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back.) YES [X] NO [ ]

28. TOTAL CHARGE $: 190 00

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.)
Joe Smith MD
SIGNED 09/30/12 DATE

32. SERVICE FACILITY LOCATION INFORMATION
General Hospital
9876 Hospital Street
Anytown IL 60610-9876
a. 567891234 b. G2A1234567890

33. BILLING PROVIDER INFO & PH# (312) 5552222
Physician Practice Inc
1234 Healthcare Street
Anytown IL 60610-1234
a. 9876543210 b. G2Z5678901234

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

Required Fields (EDI 837P Format): *Required [R] fields must be completed on all claims. Conditional [C] fields must be completed if the information applies to the situation, or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional**	**Loop ID**	**Segment**	**Notes**
N/A	**Carrier Block**			2010BB	NM103 N301 N302 N401 N402 N403	
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is	R	2000B	SBR09	Titled Claim Filing Indicator code in
1a	**Insured ID Number**	Health Plan's enrollee identification number. If submitting a claim for a newborn that does not have an identification number, enter the mother's ID number. Enter the enrollee's ID number exactly the way it appears on their Plan-issued ID card.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P.
2	**Patient's Name (Last Name, First, Middle Initial)**	Enter patient's name as it appears on the enrollee's Health plan I.D card. If submitting a claim for a newborn that does not have an ID number, enter the "Baby Girl or Baby Boy and last name. Refer to page 69-70 for additional newborn billing requirements.	R	2010CA, 20108BA	NM103 NM104 NM105 NM107	
3	**Patient's Birth Date / Sex**	MMDDYY / M or F If submitting a claim for a newborn, enter the newborn's DOB/Sex	R	2010CA, 20108BA	DMG02 DMG03	Titled Gender in 837P
4	**Insured's Name (Last, First, Middle Initial)**	Enter the Patient's name as it appears on the enrollee's Health Plan I.D card or enter the newborn's name when the	R	2010BA	NM103 NM104 NM105 NM107	Titled subscriber in 837P

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

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
9a	**Other Insured's Policy or Group #**		C	2320	SBR03	Titled Group or Policy # in 837P
9b	**Reserved for NUCC use**		Not required	N/A	N/A	Does not exist in 837P
9c	**Reserved for NUCC use**		Not required	N/A	N/A	Does not exist in 837P
9d	**Insurance Plan Name or Program Name**	Required if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other medical insurance is available, or if 9a completed.	C	2320	SBR04	Titled other Insurance Group in 837P
10a, b and c	**Is Patient's Condition Related To:**	Indicate Yes or No for each category. Is condition related to a.) Employment b.) Auto Accident c.) Other accident	R	2300	CLM11	Titled related causes code in 873P

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
10d	**Claim Codes (Designated by NUCC)**	To comply with DHS' EPSDT reporting requirements, continue to use this field to report EPSDT referral codes as follows: YD - Dental (Required for age 3 or above) YO - Other* YV- Vision YH- Hearing YB - Behavioral YM - Medical For all other claims Enter new Condition Codes as appropriate. Available 2-digit Condition Codes include nine codes for abortion services and four codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include **AD** - Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or Exacerbated by the Pregnancy itself. **W3** - Level 1 Appeal	C	2300	NTE	**NTE 01** position – input "ADD" Upper case/capital format **NTE 02** position – first six character input "EPSDT=" (upper case/capital format where the sixth character will the = sign. Input applicable referral directly after "-".
10d cont.						For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
11	**Insured's Policy Group or FECA #**	Required when other insurance is available. Complete if more than one other medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.	C	2000B	SBR03	Titled Subscriber Group or Policy # in 837P
11a	**Insured's Birth Date / Sex**	Same as # 3. Required if 11 is completed	C	2010BA	DMG02 DMG03	Titled Subscriber DOB and Gender on 837P
11b	**Other Claim ID**	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: • Y4 – Property Casualty Claim Number. Enter qualifier to the left of the vertical, dotted line, identifier to the right of the dotted line.	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P
11c	**Insurance Plan Name or Program Name**	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P
11d	**Is there another Health Benefit Plan**	Y or N in the Box? If yes, complete # 9 a-d	R	2320		If yes, indicate Y for yes. Presence of Loop 2320 indicates Y (yes) to the question on 837P

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
12	**Patient's Or Authorized Person's Signature**	On the 837, the following values are addressed as follows at Change Healthcare:	R	2300	CLM09	Titled Released of Information code in 837P.
13	**Insured's Or Authorized Person's Signature**		C	2300	CLM08	Titled Benefit Assignment Indicator in 837P
14	**Date Of Current Illness Injury, Pregnancy**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers Include: • 431 – Onset of Current Symptoms or Illness • 439 - Accident Date • 484 – Last Menstrual Period (LMP) Use the LMP for Pregnancy: **Example:**  	C	2300	DTP01 DTP03	
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 Lates Visit or Consultation • 453 Acute Manifestation • 439 Accident • 455 Last Xray	C	2300	DTP01 DTP03	

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date) 444 – First Visit or Consultation Example: 15. OTHER DATE MM DD YY QUAL 454 09 25 2005				
16	**Dates Patient Unable to Work in Current Occupation**		C	2300	DTP01 DTP03	Titled Disability from Date and Work Return Date in 837P
17	**Name Of Referring Physician or Other Source**	Required if a provider other than the enrollee's primary care physician rendered invoiced services. Enter applicable 2-digit qualifier to left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order: 1.) Referring Provider 2.) Ordering Provider 3.) Supervising Provider Qualifiers Include: DN - Referring Provider DK - Ordering Provider DQ - Supervising Provider Example: 17. NAME OF PROVIDER OR OTHER SOURCE DN JANE A. SMITH MD.	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM101 NM103 NM104 NM105 NM107	

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
17a.	**Other I.D. Number of Referring Physician**	Enter the Health Plan provider number for the referring physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the Health Plan ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. The NUCC defines the following qualifiers: **0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number **LU** Location Number (This qualifier is used for Supervising Provider only). Required if #17 is completed	C	2310A (Referring) 2010D (Supervising) 2420E (Ordering)	REF01 REF02	Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P
17b.	**National Provider Identifier (NPI)**	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	R	2310A (Referring) 2010D (Supervising) 2420E (Ordering)	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in 837P.

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
18	**Hospitalization Dates Related to Current Services**	Required when place of service is inpatient. MMDDYY (indicate from and to date)	C	2300	DPT01 DTP03	Titled Related Hospitalization on Admission and Discharge Dates in 837P.
19	**Additional Claim Information (Designated by NUCC)**	Enter additional claim information with identifying qualifiers as appropriate. For multiple items, enter three blank spaces before entering the next qualifier and	Not Required	2300	NTE PWK	
20	**Outside Lab**		C	2400	PS102	
21	**Diagnosis Or Nature of Illness or Injury. (Relate to 24E.)**	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note**: Claims with invalid diagnosis codes will be denied for payment. ("E" codes are not acceptable as primary diagnosis.)	R	2300	HIXX-02 Where XX = 01,02,03, 04,05,06, 07,08,09, 10,11,12	
22	**Resubmission Code and/or Original Ref.**	This field is required for resubmissions or adjustments/corrected claims. Enter the appropriate bill frequency code (7 or 8 – see below) left justified in the Submission Code section, and the Claim ID# of the original claim in the Original Ref. No. section of this field. • 7- Replacement of Prior Claim • 8 - Void/Cancel of Prior Claim	C **Required** for resubmitted or adjusted claims.	2300	CLM05-3 REF02 Where REF01 =F8	Send the original claim if this field is used.

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
23	**Prior Authorization Number CLIA Number Locations**	Enter the referral or Authorization number. Refer to the Provider Manual to determine if services rendered require an authorization. Laboratory Service Providers must enter CLIA number here for the location. **EDI claims**: CLIA must be represented in the 2300 loop, REF02 element.	C	2300	REF02 Where REF01-G1 REF02 Where REF01 = 9F REF02 Where REF01= X4	Titled Prior Authorization Number in 837P. Titled Referral Number in 837P. Titled CLIA Number in 837P.
24A	**Date(s) Of Service**	"From" date: MMDDYY. If the service was performed on one day leave "To" blank or re-enter "From" Date. See below for Important Note (instructions) for completing the shaded portion of field 24.	R	2400	DTP01 DTP03	Titled Service Date in 837P
24B	**Place Of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R	2300 2400	CLM05-1 SV105	Titled Facility Code Value in 837P. Titled Place of Service Code in 837P.
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	C	2400	SV105	Titled Emergency Indicator in 837P.

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
24D	**Procedures, Services or Supplies CPT/HCPCS Modifier**	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service.	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in 837P.
24E	**Diagnosis Pointer**	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service and must be entered in field 21. Do not enter diagnosis codes in 24E. Note: The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	R	2400	SV107(1-4)	Titled Diagnostic Code Pointer in 837P.
24F	**Charges**	Enter charges. A value must be entered. Enter zero ($0.00) or actual charged amount.	R	2400	SV102	Titled Line Item Charged Amount in 837P.
24G	**Days Or Units**	Enter quantity. Value entered must be greater than or equal to zero. Blank is not acceptable. (Field allows up to 3 digits)	R	2400	SV104	Titled Service Unit Count in 837P.

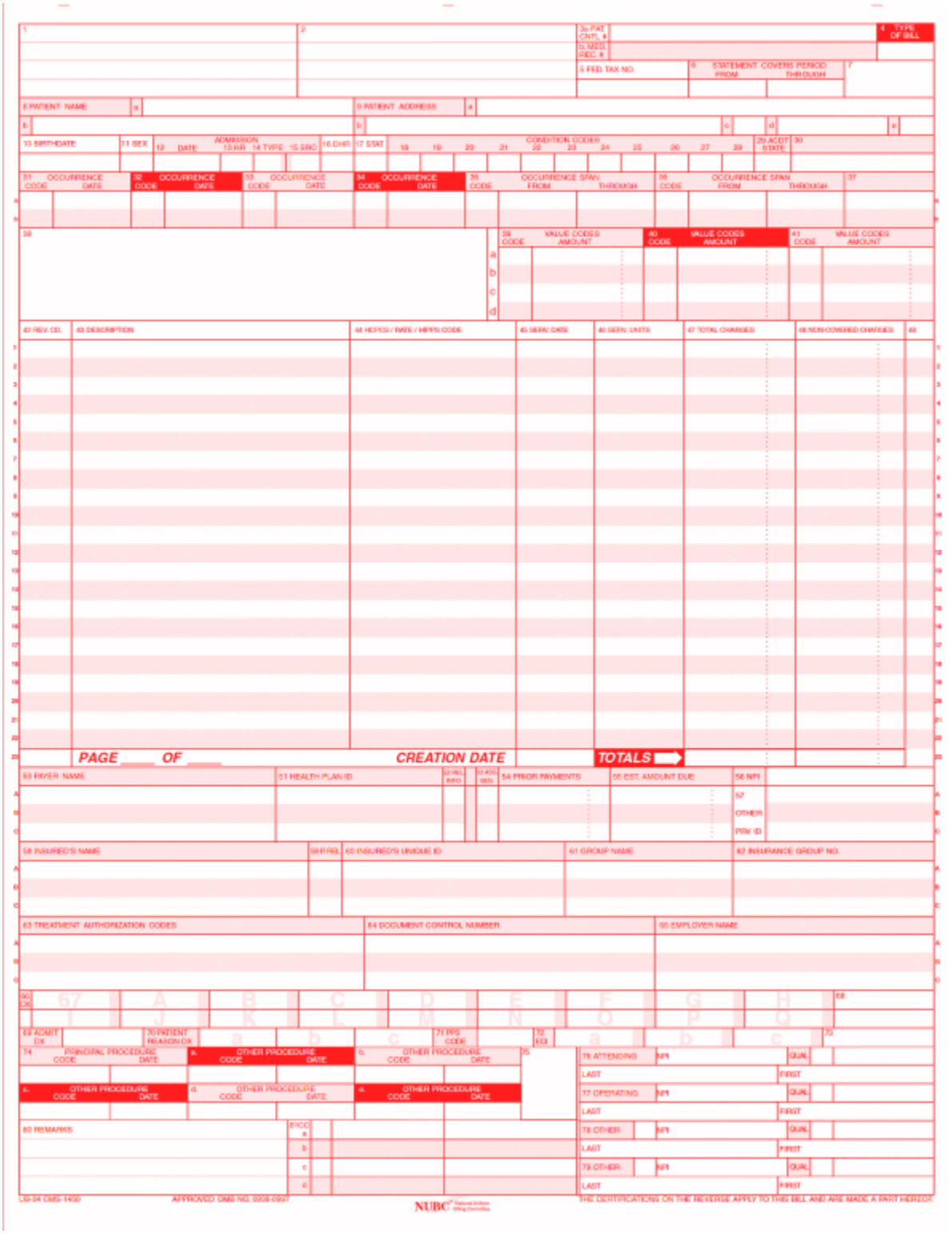
CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
24H	**EPSDT Family Plan**	**In Shaded area of field:** **AV** - Patient refused referral. **S2** - Patient is currently under treatment for referred diagnostic or corrective health problems. **NU** - No referral given or **ST** - Referral to another provider for diagnostic or corrective treatment. **In unshaded area of field:** "Y" for Yes - if service relates to a pregnancy or family planning. "N" for No - if service does not relate to pregnancy or family planning	C	2300 2400	CRC SV111 SV112	
24I	**ID Qualifier**	If rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier field in **24I**. G2 Provider Commercial Number. If the rendering provider does have an NPI see field **24J** below. If the Other ID number is the Health Plan ID number, enter G2.	R	2310B	REF (01) NM108	Titled Reference Identification Qualifier in 837P. XX required for NPI in NM109.
24J	**Rendering Provider ID**	The Individual rendering the service is reported in **24J**. Enter the Provider Health Plan legacy ID number in the shaded area of the field. Use Qualifier G2 for Provider Health Plan legacy ID. Enter the NPI number in the unshaded area of the field. Use qualifier	R	2310B	REF02	Change HealthCare will pass this ID on the claim when present.
25	**Federal Tax I.D. Number SSN/EIN**	Physician or Supplier's Federal Tax ID numbers	R	2010AA	REF01 REF02	EI Tax SY SSN

CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
26	**Patient's Account No.**	The Provider's billing account number.	R	2300	CLM01	Titled Patient Control Number in 837P.
27	**Accept Assignment**	Always indicate **Yes**. Refer to the back of the CMS 1500 (08-05) form for the section pertaining to the Medicaid Payments.	R	2300	CLM07	Titled Assignment or Plan Participation Code in 837P.
28	**Total Charge**	Enter Charges. A value must be entered. Enter zero (0.00) or actual charges (this includes capitated services). Blank is not acceptable.	R	2300	CLM02	May be $0.00
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 payer of last resort.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	**Reserved for NUCC Use**		Not Required			
31	**Signature Of Physician or Supplier Including Degrees or Credentials /Date**	Actual signature or Signature on file is required.	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P.

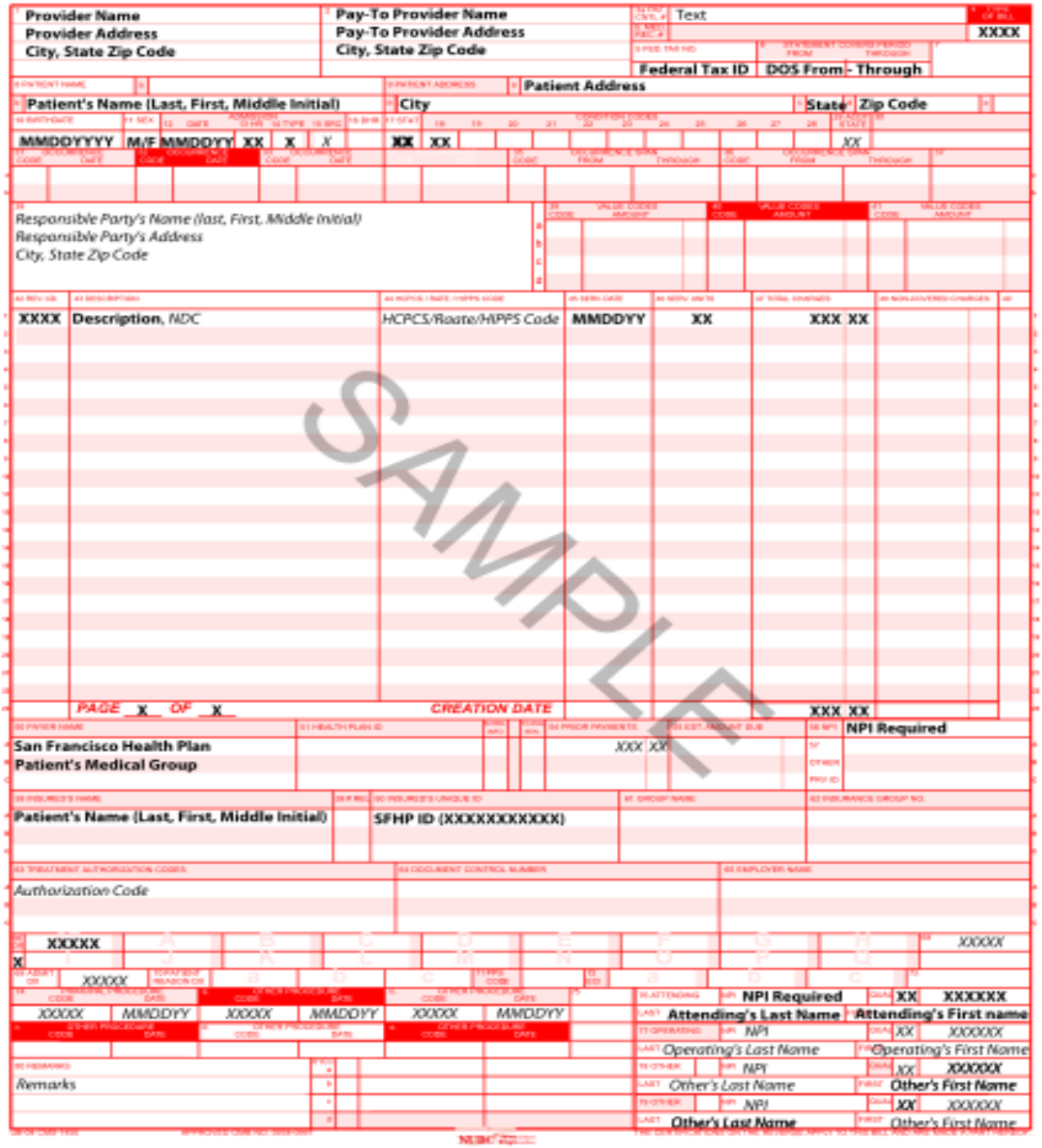
CMS - 1500 Claim Form		EDI 837P				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
32	**Name and Address of Facility Where Services Were Rendered (If other than Home or Office)**	**Required** unless #33 is the same information. Enter the physical location. **(P.O. Box #'s are not acceptable here)**	R	2310C	NM103 N301 N401 N402 N403	
32a.	**NPI number**	Required unless Rendering Provider is Atypical Provider and is not required to have an NPI number.	R	2310C	NM109	
32b.	**Other ID#**	Enter the Health Plan ID# (Strongly recommended) Enter the G2 qualifier followed by the Health Plan ID# The NUCC defines the following qualifiers used in 5010A1: **OB** State License Number **G2** Provider Commercial Number **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID#. Do not enter a space, hyphen, or other separator between the qualifier and number.	C	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility secondary Identifier in 837P.

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

UB - 04 CMS CLAIM FORM



CMS UB-04 Claim Form - *Completed*



Required Fields (EDI 837I Format): *Required [R] fields must be completed on all claims. Conditional [C] fields must be completed if the information applies to the situation, or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

Bill Type(s): Inpatient & Outpatient

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X, 22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
1	**Unlabeled Field NUBC - Billing Provider Name, Address and Telephone Number**	Service Location, No PO Boxes Left justified **Line a**: Enter the complete provider's name. **Line b:** Enter the complete address. **Line c**: City, State and Zip code + 4 digits **Line d:** Enter the area code, telephone number.	R	R	2010AA	NM1/85 N3 N4	
2	**Unlabeled Field NUBC - Pay-to Name and Address**	Enter Remit Address No P.O. Boxes	R	R	2010AB	NM1/87 N3 N4	
3a	**Patient Control No.**	Provider's Patient account/control number	R	R	2300	CLM01	
3b	**Medical/Health Record Number**	The number assigned to the patient's medical/health record by the provider	C	C	2300	REF02 where REF01 = EA	Medical Reference Number

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
4	**Type of Bill**	Enter the appropriate three or four - digit code. 1st position is a leading zero - Do not include the leading zero on the electronic claim(s). 2nd position indicates type of facility. 3rd position indicates type of care. 4th position indicates billing sequence.	R	R	2300	CLM05	If Adjustment or Replacement or Void claim, include frequency code as the last digit. Include the frequency code by using bill type in loop 2300. Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number. No dashes or spaces
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	R	R	2010AA	REF02 Where REF01 = EI	Pay to provider = Billing Prov use 2010AA Billing Provider Tax ID
6	**Statement Covers Period From/Through**	Enter dates for the full range(s) of services being invoiced. (MMDDYY)	R	R	2300	DTP03 where DTP01 = 434	MMDDCCYY Statement dates

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
7	**Unlabeled Field**	NOT USED. Leave Blank					
8a	**Patient Identified**	Patient Health Plan ID is conditional if number is different from field 60.	R	R	2010 BA 2010 CA	NM109 where NM101 = IL NM109 where NM101= QC	Patient = Subscriber Use 2010BA Subscriber ID Patient is not = Subscriber, Use 2010CA Patient ID
8b	**Patient Name**	Patient name is required. Last name, first name and middle initial. Enter the patient's name as it appears on the Health Plan ID card. Use a comma or space to separate the last and first names. **Titles:** (Mr., Mrs., etc.) Should not be reported in this field. **Prefix:** No space should be left after the prefix of a name e.g., McKendrick. Hyphenated names: Both names should be capitalized and separated by a hyphen (no spaces)	R	R	2010 BA 2010 CA	NM103, NM104, NM107 where NM101 = IL NM103, NM104, NM107where NM101 = QC	Patient = Subscriber, Use 2010BA Subscriber Name Patient is not = Subscriber, Use 2010CA Patient Name

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
8b cont.		**Suffix**: A space should separate a last name and suffix. **Newborns and Multiple Births:** If submitting a claim for a newborn that does not have and Identification number, enter "Baby Girl" or Baby Boy" and last name.					
9a-e	**Patient Address**	The mailing address of the patient: 9a. Street Address 9b. City 9c. State 9d. Zip Code + 4 9e. Country Code (report if other than USA)	R	R	2010BA 2010CA	N301, N302 N401, 02, 03, 04 N301, N302 N401, 02, 03, 04	Patient = Subscriber, Use 2010BA Subscriber Address Patient is not =Subscriber, Use 2010CA Patient Address
10	**Patient Birth Date**	The date of birth of the patient Right justified; MMDDYYYY	R	R	2010BA 2010CA	DMG02 DMG02	Subscriber Demographic Info
11	**Patient Sex**	The sex of the patient recorded at admission, outpatient service, or start of care. M = male, F = female or U = unknown	R	R	2010BA 2010CA	DMG03 DMG03	Subscriber Demographic Info

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
12	**Admission Date**	The start date for this episode of care. For inpatient services, this is the date of admission. Right - Justified	R	R	2300	DTP03 where DTP01= 43 5	Required on Inpatient.
13	**Admission Hour**	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R for bill type S other than 21X	R	2300	DTP03 where DTP01= 43 5	Required on Inpatient. Admission date/HR
14	**Admission Type**	A code indicating the priority of this admission/visit	R	R	2300	CL101	Institutional Claim Code
15	**Point of Origin for Admission or Visit**	A code indicating the source of the referral for this admission or visit.	R	R	2300	CL102	Institutional Claim Code
16	**Discharge Hour**	Valid national NUBC Code indicating the discharge hour of the patient from inpatient care.	R	R	2300	DTP03 where DTP01 =09 6	
17	**Patient Discharge Status**	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6.	R	R	2300	CL103	Institutional Claim Code

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
18 - 28	**Condition Codes The following is unique to Medicare eligible Nursing Facilities. Condition codes should be billed when Medicare Part A does not cover Nursing Facility Services**	When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed: Condition codes: Enter condition code X2 or X4 when one of the following criteria is applicable to the nursing facility service for which you are billing: • There was no 3- day prior hospital stays. • The resident was not transferred within 30 days of a hospital discharge. • The resident's 100 benefit days are exhausted	C	C	2300	HIXX-2	HIXX-1=BG Condition info
	Applicable Condition Codes: **X2- Medicare EOMB on File** **X4- Medicare Denial on File**	• There was no 60-day break in daily skilled care. • Medical Necessity Requirements are not met • Daily Skilled care requirements are not met All other fields must be completed as per the appropriate billing guide					

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			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
29	**Accident State**	The accident state field contains the two-digit state abbreviation where the accident occurred. Required when applicable.	C	C	2300	REF02 Where REF01 = LU	
30	**Unlabeled Field**	Leave Blank					Reserved for future use
31a, b - 34a, b	**Occurrence Codes and Dates**	Enter the appropriate occurrence code and date. Code must be 01 – 69, or A0-A9 or B1. Dates must be in YYYYMMDD format. **Required** when applicable	C	C	2300	HIXX-2	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. Code must be 70 – 99 or M0-Z9. Dates must be in MMDDYY format. **Required** when applicable	C	C	2300	HIXX-2	HIXX -1 = BI
37a, b	**EPSDT Referral Code**	**Required** when applicable. Enter the applicable 2- character EPSDT Referral Code for referrals made or needed because of the screen.	C	C	2300	K3	NTE 01 position - input "ADD" Upper case/capital format. NTE 02 position - first six-character input

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
37b cont.		YD – Dental *(Required for Age 3 and above) YO – Other YV – Vision YH – Hearing YB – Behavioral YM – medical	C C C C C C	C C C C C C			"EPSDT=" (upper case/capital format where the sixth character will the = sign. Input applicable referral directly after "=" For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO ~ Use K3 with HIPPA Compliant codes.
38	**Responsible Party Name and Address**	The name and address of the party responsible for the bill.	C	C			Not required Not mapped 837I
39a, b, c, d - 41a, b, c, d	**Value Codes and Amounts**	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Codes and amounts. If more than one value code applies, list in alphanumeric order.	C	C	2300	HIXX - 2 HIXX - 5	HIXX - 1 = BE

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21 X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
cont.		**Required** when applicable. **Note**: **If value code is populated then value amount must also be populated and vice versa**. Please see NUCC Specifications Manual Instructions for value codes and descriptions. **Documenting covered and non-covered days:** Value					
cont.		Code 81 – non-covered days; 82 to report coinsurance days; 83-Lifetime reserve days. Code in the code portion and the Number of Days in the “Dollar” portion of the “Amount” section. Enter “00” in the “Cents” field.					
42	**REV. Code**	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. Hospital: Enter the rev code that corresponds to the rev description in field 43. Refer to NUBC for valid rev codes. The last entry on the claim detail lines should be 0001 for total charges.	R	R	2400	SV201	Revenue Code

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
42 cont.	**REV. Code**	PPED: use the rev code that appears on the approved prior authorization letter for covered services. LTC state facility: use rev code 0100 for room and board, plus ancillary LTC non-state/assisted living: use rev code 0101 for room and board, without ancillary. Use appropriate rev code for covered ancillary service. Leave of Absence codes: LTC – state and non-state facilities: use LOA rev codes 0183, 0185 and 0189 as appropriate. Assisted Living Facilities: use only 0189 as a LOA code, no payment is made for days billed with rev code 0189. Use for any days when patient is out of the facility for the entire day.					
43	**Revenue Description**	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category. Use this field to enter NDC information. Refer to supplemental information section.	R	R	N/A	N/A	Not mapped 837I

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			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
44	**HCPCS/Accommodation Rates/HIPPS Rate Codes**	**1.** The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary service and outpatient bills. **2.** The accommodation rate for inpatient bills. **3.** Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patients 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.)	R	R	2400	SV202-2	SV202-1= HC/HP
45	**Serv. Date**	Report line-item dates of service for each revenue code or HCPCS/HIPPS code. Multiple-day service codes require an RR modifier.	R	R	2400	DTP03 where DTP01=472	Date of Service

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X ,22X,32X	Outpatient Bill Type: 13X,23X,33 X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
46	**Serv. Units**	Report units of service. A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Note: for drugs, service units must be consistent with the NDC code and its unit of measure. NDC unit of measure must be a valid HIPAA UOM code or claim may be rejected.	R	R	2400	SV205	Service Units
47	**Total Charges**	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total Charges includes both covered and noncovered charges. Report grand total of submitted charges. Enter a zero ($0.00) or actual charged amount.	R	R	2300	SV203	Total Charges
48	**Non- Covered Charges**	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code. Required when Medicare is Primary.	C	C	2400	SV207	Non-Covered Charges

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
49	**Unlabeled Field**		Not Required	Not Required			
50	**Payer**	Enter the name for each Payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary	R	R	2000B 2010BA 2320 2330B	SBR NM103 where NM101= P R SBR NM103 where NM101= PR	Subscriber Information Payer Name Other Subscriber Information Other Payer Name
51	**Health Plan Identification Number**	The number used by the Health Plan to identify itself. ACDC's Payer ID is #77002	R	R	2330B	NM109 Where	Payer ID
52	**Rel. Info**	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is expected that the provider has all necessary release information on file. It is expected that all released invoices contain "Y"	R	R	2300	CLM09	Release of Information code

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21 X,22X,32X	Outpatient Bill Type: 13X,23X,33 X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segmen t**	**Notes**
53	**Asg. Ben.**	Valid entries are "Y" (yes) and "N" (no). The A, B, C indicates refer to the information in the Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	R	R	2300	CLM08	Benefits Assignme nt Certificatio n Indicator
54	**Prior Payments**	The A, B, C indicators refer to the information in Field 50. The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	C	C	2320	AMT02 where AMT01= D	Prior Payments
55	**Est. Amount Due**	Enter the estimated amount due (the difference between “Total Charges” and any deductions such as other coverage).	C	C		AMT02 where AMT01 =EA	Payment Estimated Amount Due
56	**National Provider Identifier – Billing Provider**	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier. Required if the health care provider is a Covered Entity as defined in HIPAA Regulations.	R	R	2010 AA	NM109 where NM101 =	NPI

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X, 22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
57 A, B, C	**Other (Billing) Provider Identifier**	A unique identification number assigned to the provider submitting the bill by the health plan. Required for providers not submitting NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50 A, B and C. Use Modifier G2 if using health plan legacy ID	C	C	2010 AA 2010 BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 =	Tax ID Only sent if need to determine the Plan ID Legacy ID
58	**Insured's Name**	Information refers to the payers listed in field 50. In most cases this will be the patient's name. When other coverage is available, the insured is indicated here.	R	R	2010 BA	NM103, NM104, NM 105 where NM101 =	Use 2010BA is insured is subscriber
59	**P. Rel**	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. **Code 01**: Patient is Insured **Code 18**: Self	R	R	2000 B	SBR02	Individual Relationship code
60	**Insured's Unique Identifier**	Enter the patient's Health Plan ID on the appropriate line, exactly as it appears on the patient's ID card online B or C. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2010 BA	NM109 where NM101=IL REF02 where REF01 = SY	Insured's Unique ID

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X ,22X,32X	Outpatient Bill Type: 13X,23X,33 X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
61	**Group Name**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line: **A** refers to the primary payer; **B**, secondary; and **C**, tertiary	C	C	2000 B	SBR04	Subscriber Group Name
62	**Insurance Group No.**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line: **A** refers to the primary payer; **B**, secondary; and **C**, tertiary	C	C	2000 B	SBR03	Subscriber Group or Policy Number
63	**Treatment Authorization Codes**	Enter the Health Plan referral or authorization number. Line: **A** refers to the primary payer; **B**, secondary; and **C**, tertiary.	R	R	2300	REF02 where REF01 = G1	Prior Authorization Number
64	**DCN**	Document Control Number. New field. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code. The ESC field has been eliminated. Note: Resubmitted claims must contain the original claim ID.	C	C	2320	REF02 where REF01 = F8	Original Claim Number

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
65	**Employer Name**	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2320	SBR04	
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. Note: Claims with invalid codes will be denied for payment.	R	Not Required	2300	Determined by the qualifier submitted on the claim	Not Required
67	**Prin. Diag. Cd. And Present on Admission (POA) Indicator**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	R	R	2300	HIXX-2 HIXX-9 WHERE HI01-1 = BK OR ABK	Principal Diagnosis POA

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21 X,22X,32X	Outpatient Bill Type: 13X,23X,33 X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
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	Other Diagnosis Information
68	**Unlabeled Field**						
69	**Admitting Diagnosis Code**	The appropriate ICD code describing the patient's diagnosis at the time of admission as stated by the physician. **Required** for inpatient and outpatient	R	R	2300	HI01-2 Where HI01 - 1 BJ or ABJ	Admitting diagnosis
70	**Patient's Reason for Visit**	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B and C.	C	R	2300	HIXX-2 HI01-1=PR or APR Where XX = 01,02,03	Patient Reason for visit

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
71	**Prospective Payment System (PPS) Code**	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.	C	C	2300	HI01-2 Where HI01-1 = DR	DIAGNOSIS Related Group (DRG) Information
72a-c	**External Cause of Injury (ECI) Code**	The appropriate ICD code(s) pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Required if applicable.	C	C	2300	HIXX - 2	External Cause of Injury
73	**Unlabeled Field**						
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 or Ambulatory Surgical Center** - CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C	C	2300	HI01-2 HI01-4 Where HI01-1 = BR or BBR	

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
74a-e	**Other Procedure Codes and Dates**	The appropriate ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. **Inpatient facility** – Surgical procedure code is required when a surgical procedure is performed. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C	C	2300	HIXX-2 Where HI01-1= BQ or BBQ	Other Procedure Information
75	**Unlabeled Field**						
76	**Attending Provider Name and Identifiers NPI#/ Qualifier/Other ID#**	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the attending physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician.	R	R	2310 A 2310 A 2310 A 2310 A	NM103, NM104, NM 107, NM109 where NM101 = 71 REF02 Where REF01 = G2	REF01/0B/ 1G/L U/G2 (Do not send the Provider's Plan ID)

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21 X,22X,32X	Outpatient Bill Type: 13X,23X,33 X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
76 cont.		**Note**: If a qualifier is entered, a secondary ID must be present, and if a secondary ID is present, then a qualifier must be present. Otherwise, the claim will reject.					
77	**Operating Physician Name and Identifiers – NPI#/Qualifier / Other ID#**	Enter the NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line, last name first. If the operating physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician. **Required** when a surgical procedure code is listed.	C R	C R	2310 B 2310 B	NM103, NM104, NM107, NM109 Where NM101 = 7172 REF02 Where REF01 = G	
78 -79	**Other Provider (Individual) Names and Identifiers – NPI#/Qualifier / Other ID#**	Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first.	R	R	2310 C 2310 C	NM103, NM104, NM 107, NM109 where NM101 = 71ZZ	

UB - 04 Claim Form		EDI 837I					
			Inpatient Bill Type: 11X,12X,21X,22X,32X	Outpatient Bill Type: 13X,23X,33X, 83X			
Field #	**Field Description**	**Instructions**	**Required or Conditional**	**Required or Conditional**	**Loop**	**Segment**	**Notes**
78-79 Cont.		If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#			2310C 2310C	REF02 Where REF01 = G2	
80	**Remarks Field**	Area to capture additional information necessary to adjudicate the claim.	C	C	2300	NTE02 Where NTE01 =ADD	
81CC, a-d	**Code - Code Field**	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C	2000A	PRV01 PRV03	

Claim Processing

MedStar Family Choice Claim Processing Contact Information (DC & Maryland)

MFC Website Links

- DC: https://www.MedStarFamilyChoiceDC.com/
- MD: https://www.MedStarFamilyChoice.com/

- MDH Eligibility Verification System (EVS) link: https://encrypt.emdhealthchoice.org/emedicaid/

Refund Address

MedStar Family Choice DC
DC Claims
P.O. Box 715639
Philadelphia, PA 19171-5639

MedStar Family Choice MD
Maryland Claims
P.O. Box 715639
Philadelphia, PA 19171-5639

Appeals Address

MedStar Family Choice DC
Appeals Processing
P.O. Box 43790
Baltimore, MD 21236

MedStar Family Choice
Appeals Processing
P.O. Box 43790
Baltimore, MD 21236

Payment Dispute Address

MedStar Family Choice DC
PO Box 211702
Eagan, MN 55121
ATTN: Payment Disputes
Phone: 800-261-3371

MedStar Family Choice
PO BOX 211702
Eagan, MN 55121
ATTN: Payment Disputes
Phone: 800-261-3371

Verification of Eligibility

MedStar Family Choice Members/Enrollees are provided with an Identification card indicating MedStar Family Choice as their chosen Managed Care Organization.

It is the responsibility of the provider to ensure the patient is DC Medicaid eligible on the date of service. If a provider supplies services to an ineligible beneficiary, the provider cannot collect payment from DC Medicaid.

The provider should verify:

- Beneficiary's name and identification number
- Effective dates of eligibility
- Services restricted to specified providers
- Third-party liability

The provider must verify the beneficiary's eligibility for reimbursement of services rendered.

Prior Authorization Request

MedStar Family Choice requires a prior authorization for specified services. It is very important that the step of verifying authorization requirements is done at the same time of verifying eligibility. If an authorization is not obtained prior to services rendered, there is a strong possibility that the claim for services rendered will be denied!!!! The servicing provider will not receive payment for the services rendered.

Services that require a Pre-Authorization are included on the Pre-Authorization Benefit Grid. The Benefit Grid and the Request for Authorization forms are located on the MedStar Family Choice website. Clink on the link(s) below:

- MFC Website Links
  - DC: https://www.MedStarFamilyChoiceDC.com/
  - MD: https://www.MedStarFamilyChoice.com/

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, MFC-DC will assign a prior authorization number, which refers to and documents the approval. MFC-DC sends written notice of adverse determination to the out-of-network provider within the time frames appropriate for the type of request. Occasionally, an Enrollee may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. MFC-DC makes such decisions on a case by-case basis.

Payer Descriptions

Medicaid with Primary Payor /Third Party Payer (TPL)

Medicaid is always the payer of last resort. When a beneficiary has insurance from another source, employer or private policy, the provider must bill this source first before submitting to Conduent. To bill Medicaid, the provider must submit an original claim with a copy of the third-party payers' EOMB attached indicating payment or denial within 180 days of the processing/payment date. When verifying eligibility for the patient, the provider should always question the patient about third party resources available to the patient, regardless of the information supplied through the Web Portal and IVR. In accordance with the DC Medicaid State Plan Amendment, the reimbursement for TPL claims is the difference between the third-party payer's payment and the Medicaid allowed amount, not just the deductible and coinsurance.

Dual Eligibility - Medicare /Medicaid

When a beneficiary has been determined as dual-eligible (Medicare and Medicaid), Medicare should always be billed first. The Medicare claim must include both the patient's Medicare and Medicaid identification number. After Medicare processes the claim, the claim will be transmitted to Conduent for processing electronically. The claim must be received by Conduent no later than 180 days after the Medicare paid date as indicated on the Explanation of Medical Benefits (EOMB) statement. If Medicare is billed for services for a beneficiary who is later identified as having Medicaid coverage, the provider should submit a copy of the Medicare claim to DC Medicaid. Again, the Medicare claim must include the patient's DC Medicaid identification number. The Explanation of Medical Benefits (EOMB) from Medicare must be attached to the claim as proof of payment or denial of payment by Medicare and submitted to Conduent for processing. Refer to Appendix A for the address to submit these claims.

For additional information on Medicare billing, go to
www.cms.gov/Medicare/Medicare.html or call.
Medicare at 800.633.4227.

QMB – Qualified Medicare Beneficiary

Qualified Medicare Beneficiaries (QMBs) are persons who are entitled to Medicare Part A, are eligible for Medicare Part B, and have an income below 100% of the federal poverty level are determined to be eligible for QMB status by their state Medicaid agency. Medicaid pays only the Medicare Part A and B premiums, deductibles, co-insurance, and co-payments for QMBs. Medicaid does not cover dental services or non-covered Medicare services.

Approved/Paid
Claims that meet all requirements and edits are paid during the next payment cycle. The provider will receive a Remittance Advice (RA) weekly listing all paid, denied, and suspended claims in the system. The provider will also receive a reimbursement check or direct deposit for paid claims. The RA will include claim amounts that have been processed and a total of all paid claims.
Claims previously paid incorrectly may be adjusted or voided. Voids will appear as credits; adjustments will appear as two transactions, debit, and credit.
Adjustments/voids must be initiated by the provider since the provider can only correct errors after the claim has been paid and appears on the RA.

Adjusted/Corrected Claims
The provider will be paid by check or direct deposit for all paid claims in accordance with current guidelines.

Denied
Claims that do not meet MFC Medicaid edit requirements will not be paid. All denied claims are listed on the Remittance Advice (RA) in alphabetical order by beneficiary last name. Denial reasons are listed on the RA as well. Listed below are some examples of denial reasons:

- Beneficiary not eligible on date of service
- Provider not eligible on date of service
- Duplicate claim
- Claim exceeds filing limit.

Suspended
Claims that do not meet the edit requirements cannot be paid until discrepancies have been resolved. To verify that the claim is in error, the claim is assigning a status of "Suspend" which will outline the problem to resolve the issue. Claims will suspend for a variety of reasons; however, the most common reasons for claims to suspend are due to beneficiary eligibility, provider eligibility or the claim must be manually priced. Claims that suspend should not be re-submitted. If a second claim is submitted while the initial claim is in a suspended status, both claims will suspend. Please allow the suspended claim to be processed and to be reported on the RA as paid or denied before additional action is taken.

Recoupment
If a provider has knowingly billed and been paid for undocumented or unnecessary medical services, Medstar will review the error and determine the amount of improper payment. The provider will be required to either submit payment or provide repayment through Medstar withholding future claims. If the 100% review of disputable claims becomes impractical, random sampling techniques will be implemented to determine the amount of the improper payment.

Claims Payment Dispute

The Claims Department will accept correspondence in the form of a Claims Payment Dispute form. MedStar Family Choice has developed a new form for your convenience. This form contains all the information that is required to process your request. Please complete the form in its entirety and mail or email the form to the address(s) listed below and/or on the Claims Payment Dispute form. Copies of these forms are available on the MedStar Family Choice website(s) below. Providers must use the Claims Payment Dispute form for all payment disputes, or your request will not be processed. Providers have ***90 business days from date of denial***.

DC: MedStar Family Choice DC | Home (MedStarFamilyChoiceDC.com)

MD: MedStar Family Choice | Managed Care Organization

MedStar Family Choice MD
PO Box 211702
Eagan, MN 55121
ATTN: Payment Disputes
Phone: 800-261-3371

MedStar Family Choice DC
P.O. Box 211702
Eagan, MN 55121
ATTN: Payment Disputes
Phone: 800-261-3371

Formal Appeal Process

MedStar Family Choice will accept appeal requests in writing within applicable time frames using the Clinical/Medical Necessity or Administrative Appeal Form from the website. Appeal requests must include a clearly expressed request for the appeal or re-evaluation. The request must include the reason and supporting documentation as to why the Adverse Action (denial) was believed to have been issued incorrectly. MedStar Family Choice will send a letter to confirm the appeal within 2 business days of receipt of the appeal request. MedStar Family Choice will decide within 30 days from the date of the appeal and send a letter with the decision. Providers acting on their own behalf are defined as those who dispute Adverse Actions when the service has already been provided to the enrollee and there is no enrollee financial liability. First level appeals must be submitted in writing ***within 90 business days*** from the date of the explanation of benefits (EOB/EOP) payment) denial notice to the address below:

MedStar Family Choice DC
Appeals Processing
P.O. Box 43790
Baltimore, MD 21236

MedStar Family Choice MD
Appeals Processing
P.O. Box 43790
Baltimore, MD 21236

The appeal must outline reasons for the appeal with all necessary documentation including a copy of the claim and the EOB, when applicable. Appeal requests for medical necessity decisions must include supporting clinical/medical documentation. A provider appeal must include a clearly expressed reason for re-evaluation, with an explanation as to why the denial was believed to have been issued incorrectly. An acknowledgement of receipt of the appeal (first and second level) will occur within five business days of receipt. Second level appeals must be submitted within 30 calendar days of the first level appeal notification letter.

The second level appeal is the final level of appeal. MedStar Family Choice will respond within 30 calendar days of receipt of the second level appeal. Please use the Clinical/ Medical Necessity or Administrative Appeal Form and mail the written request with all supporting documentation, such as clinical/medical documentation.

Overpayments – Refunds

If a provider receives an overpayment for a claim, please submit the refund using the Overpayment/ Refund Form located on our website (***MedStarFamilyChoiceDC.com; or MedStarFamilyChoice.com***) then send the refund along with a copy of the Remittance Advice identifying the overpayment to the address below:

MedStar Family Choice DC
DC Claims
P.O. Box 715639
Philadelphia, PA 19171-5639

MedStar Family Choice MD
Maryland Claims
P.O. Box 715639
Philadelphia, PA 19171-5639

Overpayments shall be returned to MedStar Family Choice within sixty (60) calendar days after the date on which the overpayment was identified by the Provider.

Timely Filing

All services to be reimbursed must be billed on the appropriate form, signed, and submitted to Medstar Family Choice. All hard copy claims must be mailed to their respective P.O. Box, unless otherwise instructed. The **timely filing period for Medicaid claims:**

- **DC Medicaid/Alliance - 365 Days from date of service or date of discharge**
- **Maryland Medicaid - 180 Days from date of services or date of discharge**

Secondary and tertiary Medicaid claims submitted for payment must be submitted within 180 days from the primary payer EOB date. The Explanation of Benefits (EOB) statement must be submitted with the claim.

All claims for services submitted after the Timely Filing period will not be eligible for payment except in the following situations:

- Where an initial claim is submitted within the timely filing period but is denied and resubmitted after the end of the timely filing period, the resubmitted claim shall be considered timely filed provided it is received within 365 days of the denial of the initial claim.
- If a claim for payment under Medicare or third-party payer has been filed in a timely manner, MedStar Family Choice may pay a Medicaid claim relating to the same services within 180 days of a Medicare or Third-Party Payor.

Proof of Timely Filing (POTF) for DC/MD Plan

1. **POTF is calculated from the receipt of a clean claim**. Unclean claims are NOT used to determine an acceptable receipt date.

2. For EDI claims, the POTF is a copy of the transmittal report showing the MFC ACCEPTED the claim in question. If the claim was rejected in the clearing house stage, this indicates that the claim is not clean, and this is not used to show that a claim was filed timely.

3. If the provider submits “proof” from their billing system that a claim was submitted for either an EDI or paper claims, this is NOT considered POTF. For paper claims, the provider must submit some form of receipt from MFC that the paper claim was received. Examples include, but are not limited to: FedEx receipt, signature form from USPS, etc.

4. When MFC has rejected a paper claim and sent the claim back to the provider with a rejection letter, this is NOT a clean claim; therefore, this date is not considered a valid receipt date.

5. In truly extraordinary cases, the provider can ask for a special consideration when something occurred that are beyond the provider’s ability to control. These are considered on a case-by-case basis and Provider Relations or contracting should be consulted as needed. Final approval for special considerations is based on the proposed payment amount, as to what level of management needs to approve.

Definitions:

Clean claim – has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment/processing**.**

Rejected claim - contains one or more errors found before the claim was processed. Medical claims that are rejected were never entered into the system due to data requirements were not met. Therefore, proof of timely filing does not exist.

Denied claim - received and processed by the payer and deem unpayable. Therefore, proof of timely filing is established.

Corrected Claim Submission(s)

EDI Claims – Corrections can be sent in an electronic format:

1. In the 2300 Loop, the CLM segment (Claim information), CLM5-3 (claim frequency type code) must indicate one of the following qualifier codes:
    - "7" – Replacement (Replacement of Prior Claim)
    - "8" - VOID (Void/Cancel of Prior Claim)
2. The 2300 Loop, the REF segment (Claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on the remittance advice.
3. Corrected claim bill type for UB claims is billed in Loop 2300/CLM5-1

CMS 1500(Professional) Paper Claims -

On the CMS-1500 Form, use Corrected Claim indicator (Medicaid Resubmission Code). Enter the frequency code "7" in the "Code" field and the original claim number in the "Original Ref No. field. To VOID (VOID/Cancel of Prior Claim) enter the frequency code "8" in the "Code" field and the original claim number in the "Original Ref NO". field.

UB04 (Facility) Paper Claims –

On the UB-04 (CMS 1450) Form, use Box 4 (Type of Bill). Enter either "7" (corrected claim), "5" (late charges), or "8" (VOID or Cancel a prior claim) as the third digit in Box 4 (Type of Bill). In Box 64(Document Control Number), enter the original claim number.

Member ID or Provider/ Tax ID # Denials – VOID the original claim (using frequency code "8") and to submit a new claim, clean claim using the correct Member ID# and or Billing Provider/Tax ID#.

Late Charges – all late charges must be consolidated into one claim for submission. If the late charges are received separately, they will be denied as a billing error.

NATIONAL DRUG CODE (NDC) REPORTING REQUIREMENTS

The NDC is a universal number that identifies a drug. The NDC consists of 11 digits in a 5-4-2 format. The first five digits identify the manufacturer of the drug and are assigned by the U.S. Food and Drug Administration (FDA). The remaining digits are assigned by the manufacturer and identify the specific product and package size. Some packages will display fewer than 11 digits, but leading zeros can be assumed and should be used when billing. Do not bill using invalid or obsolete NDC numbers.

Acceptable Units of Measure

There are different acceptable units of measurements that can be used when billing with NDC information. The appropriate one to use is based on the type of drug. See below for acceptable units of measure.

Code	Unit Type	Description
F2	International Unit	Products described as IU/vial or micrograms
GR	Gram	Ointments, creams, inhalers, or bulk power in a jar
ML	Milliliter	Liquid, solution, or suspension
UN	Unit (EA/Each)	Powder for injection (needs to be reconstituted), pellet, kit, patch table, device
ME	Milligram	ME is also a valid unit of measure, but we recommend using the more appropriate UN or ML unit of measure, as this is generally how drugs are priced

When to include an NDC on a claim

NDC numbers must be included ***in the correct NDC format*** on professional and institutional claims when billing for:

- Drug-related revenue codes
- Drug-related CPT codes, including miscellaneous and unlisted drug codes
- Drug-related HCPCS codes, including miscellaneous and unlisted related codes such as A, B, J, Q and S HCPCS codes.

Discarded Drugs

Modifier JW is used on a drug claim to report the amount of drug or biological that is discarded and eligible for payment. The modifier is only used for drugs in a single dose or single use packaging.

Data Elements Required to Report NDC

- A valid NDC format allows for the entry of 61 characters, without skipping a space or adding hyphens
- Report the NDC Qualifier of “N4” in the first two positions, left justified
- Immediately followed by the 11-digit NDC number in the 5-4-2 format (do not use hyphens and pad w/zeroes if needed)
- Immediately followed by one of the Unit of Measurement (UOM) Qualifiers listed below (2-digit):
    - F2 International Unit
    - GR Gram
    - ML Milliliter
    - UN Units (EA/Each
    - ME Milligram

Immediately followed by the NDC Unit Quantity administered to the patient. The Unit Quantity with a floating decimal for fractional units is limited to three (3) digits to the right of the decimal point. A maximum of seven (7) positions to the left of the floating decimal may be reported.

- When reporting a whole number, do not key the floating decimal.
- When reporting fractional units, you must enter the decimal as part of the entry.

Sample National Drug Code:

Whole Number Unit:
N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 5 6 7

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

Professional (CMS -1500 CLAIM FORM 1500) Paper Claim Submission

Providers are required to bill an NDC number, NDC unit of measure, and NDC units administered, as well as the HCPCS equivalent code on a claim. If the NDC number on the claim does not have a specific HCPCS or CPT code assigned to it, please assign the appropriate miscellaneous code.

The NDC number reported must be the actual NDC number on the package or container from which the medication was administered.

Using the CMS - 1500 form, enter the NDC information in field 24. There are six service lines in field 24 with shaded areas. Place the NDC information in the claim line’s top shaded part of field 24A.

Example:

24. A. Dates(s) of Service From MM	DD	YY	To MM	DD	YY	B. Place of Service	C. EMG	D. Procedures, Services, or Supplies CPT/HCPCS	Modifier	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID QUAL	J. RENDERING PROVIDER ID#
N460793070010 ML1															
09	01	19	09	01	19	11		J0561		A	12	00	6	NPI	123456789

When entering the supplemental NDC information for the NDC, add it in the following order:

- "N4" qualifier
- 11-digit NDC code
- Add one space
- Two-character unit of measure and the quantity

Professional (837P) Electronic Claim Submission

Providers are required to bill an NDC number, NDC unit of measure, and NDC units administered, as well as the HCPCS equivalent code on a claim. If the NDC number on the claim does not have a specific HCPCS or CPT code assigned to it, please assign the appropriate miscellaneous code.

Loop	Segment	Element Name	Information
2410	LIN	2	Product or Service ID Qualifier - If billing for an NDC, enter N4
2410	LIN	3	Product or Service ID - If billing for drugs, include the 11 - digit NDC **Sample**: LIN**N4*12345678901
2410	CTP	4	Quantity - If an NDC was submitted in LIN03, include the administered NDC quantity
2410	CTP	05-1	Unit or Basis for Measurement Code - If an NDC was submitted in LIN03, including the unit or basis for measurement code for the NDC billed **Sample**: CTP ****3*UN

Facility (UB04) Paper Claim Submission

When billing a facility claim, include the applicable Revenue code, NDC number, NDC unit of measure, and NDC units administered, as well as the HCPCS equivalent code when appropriate.

The NDC number reported must be the actual NDC number on the package or container from which the medication was administered.

Using the UB04 form, enter the NDC information in Form Locator (FL) 43 and fill out the following fields: • FL 42 – Include the appropriate revenue code.
• FL 43 – Include the 11-digit NDC code, unit of measurement and quantity
• FL 44 – Include the HCPCS code if required

Example:

42. REV CO	43. DESCRIPTION	44. HCPCS /RATE /HPPS CODE	45. SERV. DATE	46. SERV UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49
636	N412345678901	HCPCS		1	10	0	

When entering the supplemental NDC information for the NDC, add it in the following order:

- "N4" qualifier
- 11 – digit NDC code
- Add one space.
- Two-character unit of measure and the quality

Facility (837I) Electronic Claim Submission
When billing a facility claim, include the applicable Revenue code, NDC number, NDC unit of measure, and NDC units administered, as well ad the HCPCS equivalent code when applicable.

Loop	Segment	Element Name	Information
2410	LIN	2	Product or Service ID Qualifier - If billing for an NDC, enter N4
2410	LIN	3	Product or Service ID - If billing for drugs, include the 11 - digit NDC **Sample**: LIN**N4*12345678901
2410	CTP	4	Quantity - If an NDC was submitted in LIN03, include the administered NDC quantity
2410	CTP	05-1	Unit or Basis for Measurement Code - If an NDC was submitted in LIN03, including the unit or basis for measurement code for the NDC billed **Sample**: CTP ****3*UN

340B - ***Hospital facilities and Federal Qualified Health Centers participating in the 340B program are not required to bill an NDC number.***

Fraud Waste and Abuse

MedStar Family Choice has comprehensive Compliance programs in place to monitor and detect fraud, waste, and abuse. Fraud, waste, and abuse can be committed by a provider, Enrollee, or even a MedStar Family Choice employee. As a MedStar Family Choice provider, it is your responsibility to report fraud, waste, or abuse.

Fraud – *is defined as the wrongful deception intended to result in financial or personal gain*. Is knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any health care benefit program; or to obtain, by any means of false or fraudulent pretenses, representations or promises, any of the money or property owned by or under the custody or control of, any health care benefit program. This violates criminal law.

Examples Include:

- Billing for non - existent services, labs, or prescriptions or office visits.
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Waste - Over utilization of services or other practices that, directly or indirectly result in unnecessary costs to government programs like Medicare and Medicaid.

Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Examples include:

- Conducting excessive office visits
- Ordering excessive Laboratory tests

Abuse – Include actions that may, directly or indirectly, result in unnecessary costs to the federal health care program.

Abuse involves payment for items or services when there is no legal entitlement, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples include:

- Knowingly billing for services procedures or tests not performed by the provider, office, or entity.

Reporting Fraud Waste & Abuse

MedStar Family Choice is committed to the investigation, prevention, and detection of provider and beneficiary fraud and/or abuse in the Medicaid program. Providers suspecting fraud, waste and/or abuse must report this immediately by contacting any of the following:

MedStar Family Choice District of Columbia

- MedStar Family Choice Compliance/Integrity Hotline at **877-811-3411**
- Website for compliance reporting <https://www.compliance-helpline.com/medstar.jsp>
- MedStar Office of Corporate Business Integrity (OCBI) can be contacted via email at <compliance@medstar.net> or phone at **(410) 772-6606**

Providers may remain anonymous, and all reports will be kept as confidential as possible. In addition, MFC-DC enforces a non-retaliation policy for those individuals reporting possible fraud, waste, and abuse activities.

Providers may also notify the Department of Health Care Finance in writing:

Department of Health Care Finance
Division of Program Integrity
441 Fourth Street, NW
Washington, D.C. 20001
Telephone Number: 202 698-1718 Hotline Phone Number: 1-877-632-2873
https://www.dc-medicaid.com/dcwebportal/nonsecure/reportFraud

MedStar Family Choice Maryland HealthChoice

- MedStar Family Choice Maryland HealthChoice Compliance Director at **410-933-3411**
- MedStar Family Choice Maryland HealthChoice Provider Relations at **800-905-1722**
- MedStar Family Choice Compliance/Integrity Hotline at **877-811-3411**

Providers may also report fraud, waste, and abuse to the following government agencies:

- MDH Office of the Inspector General at **410-767-5784** or **866-770-7175**
- Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General at **410-576-6521** or **888-743-0023**
- Federal Office of Inspector General in the US Department of Health and Human Services at **800-HHS-TIPS (800-447-8477)**

Providers may remain anonymous, and all reports will be kept as confidential as possible. In addition, MedStar Family Choice Maryland HealthChoice enforces a non-retaliation policy for those individuals reporting possible fraud, waste, and abuse activities.

General Billing Tips

1. **Verifying Eligibility** – Verify recipient eligibility for Medicaid benefits and services at the beginning of each month or at each visit. Recipients may be enrolled in programs with restricted services. Certain services require prior approval for reimbursement. Please refer to the fee schedule to confirm if a PA is required. This information may be obtained from the Interactive Voice Response (IVR) system by calling **(202) 906-8319** (in District) or **(866) 752-9231**(outside DC metro area). The IVR will prompt you to enter your provider number. This is the nine-digit number assigned to you through the Medicaid program. The system will then prompt you to enter the recipient number. This eight-digit code is listed on the patient's Medical Assistance Card. Maryland Providers can verify eligibility through EVS prior to rendering services to MedStar Family Choice members. The number for EVS is **866-710-1447.** The MDH also allows providers to verify eligibility on-line. The website is EMDHealthChoice.org

2. **IVR** - Remember to utilize the Interactive Voice Response (IVR) system or the Web Portal for eligibility inquiries.

3. **Retroactive Eligibility** – When a recipient receives retroactive eligibility, include an attachment indicating the recipient's retroactive eligibility.

4. **Patient Control Number Claim Field** – On the UB04 claim form, the Medical Record Number field (3a), is for the provider's internal use. This is a 20-character field in which the provider may report an internal patient ID number, medical record number, etc. The number entered in this field is printed on the provider's Remittance Advice.

5. **Place of Service Codes** – Place of Service codes are two (2) digit nationally recognized codes. Refer to the billing manuals for a complete list of the codes.

6. **Timely Filing TCN** – Claims for covered services must be filed within 365 days in D.C. and 180 days in Maryland from the date of service. Timely filing guidelines for Medicare/Medicaid Crossover and third-party claims are 180 days from the Medicare or third-party payer's payment date.

   Claims filed within 365 days of the date of service in D.C and 180 days in Maryland that were denied for any reason other than timely filing may be resubmitted with a copy of the Remittance Advice (RA) indicating the original date of denial.

   Adjustments may be submitted within 365 days of the paid date. Voids may be submitted at any time.

7. **Durable Medical Equipment/Medically Unlikely Edits (MUE) -** Effective January 1, 2023, MedStar Family Choice – Maryland HealthChoice will discontinue the use of the Centers for Medicaid and Medicare Services (CMS) Medicaid MUE and will begin using the Maryland Department of Health (MDH) Medicaid MUE for all Durable Medical Equipment and Supplies. The MDH MUE for each covered item may be found on the MDH DME.DMS.Oxygen Fee Schedule, which may be located using the below website link.

   https://health.maryland.gov/mmcp/communitysupport/pages/approvedlist.aspx?RootFolder=%2Fmmcp%2Fcommunitysupport%2FApproved%20Items%20Lists%2F2022&FolderCTID=0x012000F2400F8E7A70174A848E75683244C61E&View={49E8488F-0C6B-452C-A830-5CBE021D77ED}

   When billing for Durable Medical Equipment and Supplies follow the MUE to determine if a billed item requires a single date of service or a date of service span.

8. **NDC Code Requirements** - The NDC is a universal number that identifies a drug. The NDC consists of eleven digits in a 5-4-2 format. The first five digits identify the manufacturer of the drug and are assigned by the U.S. Food and Drug Administration (FDA). The remaining digits are assigned by the manufacturer and identify the specific product and package size. Some packages will display fewer than 11 digits, but leading zeros can be assumed and should be used when billing. **Do not bill using invalid or obsolete NDC numbers.**

9. **CMS-1500 CLAIM FORM -1500 Form Locator 24J Effective January 1,2023** - MFC will no longer require the Rendering Provider Identification Number in Form Locator 24J of the Professional CMS -1500 Paper Claim or Form Locator 24J in the Loop 2310B and 2420A, Segments PRV02, REF01, and NM109 of the Professional (837P) Electronic Claim for the taxonomies in the Grid included below:

PROVIDER TAXONOMY CODE	PROVIDER TAXONOMY DESCRIPTION
341600000X	Ambulance
3416A0800X	Ambulance, Air Transport
3416L0300X	Ambulance, Land Transport
3416S0300X	Ambulance, Water Transport
261QS1200X	Ambulatory Health Care Facilities: Clinic/Center: Sleep Disorder Diagnostic
261Q00000X	Clinic/ Center
291U00000X	Clinical Medical Laboratory
332B00000X	Durable Medical Equipment & Medical Supplies
332BC3200X	Durable Medical Equipment & Medical Supplies, Customized Equipment
332BD1200X	Durable Medical Equipment & Medical Supplies, Dialysis Equipment & Supplies
332BN1400X	Durable Medical Equipment& Medical Supplies, Nursing Facility Supplies
332BX2000X	Durable Medical Equipment & Medical Supplies, Oxygen Equipment & Supplies
332BP3500X	Durable Medical Equipment & Medical Supplies, Parental & Enteral Nutrition
332U00000X	Home Delivered Meals
251F00000X	Home Infusion
261QI0500X	Infusion/Injectables
174H00000X	Other Services Providers: Health Educator (DPP Providers)
333600000X	Pharmacy

PROVIDER TAXONOMY CODE	PROVIDER TAXONOMY DESCRIPTION
3336C0002X	Pharmacy, Clinic Pharmacy
3336C0003X	Pharmacy, Community/Retail Pharmacy
3336C0004X	Pharmacy, Compounding Pharmacy
3336H0001X	Pharmacy, Home Infusion Therapy Pharmacy
3336I0012X	Pharmacy, Institutional Pharmacy
3336L0003X	Pharmacy, Long Term Care Pharmacy
3336M0002X	Pharmacy, Mail Order Pharmacy
3336M0003X	Pharmacy, Managed Care Organization Pharmacy
3336N0007X	Pharmacy, Nuclear Pharmacy
3336S0011X	Pharmacy, Specialty Pharmacy
293D00000X	Physiological Laboratory
335V00000X	Portable X-ray and/or Other Portable Diagnostic Imaging Supplier
335E00000X	Prosthetic/Orthotic Supplier

To avoid future claim denials, do not include the individual practitioner's National Provider Identification number or the Type II group National Provider Identification number as the Rendering Provider in Form Locator **24J** of the Professional **CMS-1500 CLAIM FORM-1500 Paper Claim** or the Professional **(837P)** Electronic Claim.

Terms, Definitions and Abbreviations

Provider Terms

Referring Provider - The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported.
Examples include, but are not limited to, primary care provider referring to a specialist; orthodontist referring to an oral and maxillofacial surgeon; physician referring to a physical therapist; provider referring to a home health agency.

Ordering Provider - the individual who requested the services or items being reported on this service line. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.

Rendering Provider 5010A1 837P - The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here.

Future Versions of 837P - The Rendering Provider is the individual who provided the care. In the case where a substitute provider was used, that individual is considered the Rendering Provider.

The Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.

Supervising Provider - The Supervising Provider is the individual who provided oversight of the Rendering Provider and the care being reported.
An example includes, but is not limited to, supervision of a resident physician.

Purchased Service Provider - A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis for a separate provider who is billing for the service.

Examples of services include but are not limited to: (a) processing a laboratory specimen; (b) grinding eyeglass lenses to the specifications of the Rendering Provider; or (c) performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule. In the case where a substitute provider (a locum tenens physician) is used, that individual is not considered a Purchased Service Provider. Version 6.0 7/18 5

Individual Terms

Patient - An individual who has received, is receiving, or intends to receive health care services. (Health care services as defined by federal and state regulations.)

Dependent - An individual who has insurance coverage under the policy of another individual.

Subscriber - An individual or entity that is the holder of an insurance policy (including health, property, and casualty, auto, workers' compensation, or other liability) for the purposes of health care services.

Insured - An individual or entity that has insurance coverage. Version 6.0 7/18 5

Definitions & Abbreviations

The definitions relate to the term used in the MedStar Family Choice Medicaid Program:

ACA – Affordable Care Act was signed into law by President Obama on March 23, 2010, it aims to bring comprehensive and equitable health insurance coverage to many Americans. The ACA guarantees.

ADA – American Dental Association Adjustment – A transaction that changes any information on a claim that has been paid. A successful adjustment transaction creates a credit record, which reverses the original claim payment, and a debit record that replaces the original payment with a corrected amount; a change submitted because of a billing or processing error.

ANSI - American National Standards Institute Approved - A term that describes a claim that will be or has been paid.

ASC - Ambulatory Surgery Code

Automated Client Eligibility Determination System (ACEDS) - The combined eligibility determination system providing integrated automated support for several District of Columbia programs, including Medicaid.

Buy-In - The process whereby DHCF authorizes payments of the monthly premiums for Medicare coverage.

CFR – Code of Federal Regulations CHAMPUS - Civilian Health and Medical Program of the Uniformed Services

CHIP – Children's Health Insurance Program is a program administrated by the US Department of Health and Human Services that provides matching funds to states for health insurance to families with children. CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.

Claim - A request for reimbursement of services that have been rendered.

Claim Status - The determined status of a claim: approved, denied, or suspended.

Claim Type - A classification of claim origin or type of service provided to a beneficiary.

Clean claim – has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment/processing**.**

CLIA – Clinical Laboratory Improvement Amendments CMS - Centers for Medicaid and Medicare Services

CMS-1500 CLAIM - Claim form currently mandated by CMS, formerly known as HCFA-1500, for submission of practitioner and supplier services.

Conduent – is the fiscal agent for the DC Medicaid Program (formerly known as Affiliated Computer Services)

Cost Settlement – Refers to a reimbursement method in which the reimbursement is made on actual cost information.

Covered Services - All services which providers enrolled in the DC Medicaid program are either required to provide or are required to arrange to have provided to eligible beneficiaries.

CPT - Current Procedural Terminology code

Crossover - The process by which the Medicare intermediaries and Medicare carriers supply Medicaid with the deductible and co-insurance amounts to be paid by Medicaid.

DCID - District of Columbia's eight-digit beneficiary ID number

DCMMIS - District of Columbia Medicaid Management Information System

Denied – A term that describes a claim that results in nonpayment.

DHCF - Department of Health Care Finance (formerly known as Medical Assistance Administration (MAA). The name of the local District agency administering the Medicaid program and performs other necessary Medicaid functions.

DHHS - Department of Health and Human Services

DHR - Department of Human Resources

DHS - Department of Human Services

District - The District of Columbia

DME – Durable Medical Equipment

DMERC - Durable Medical Equipment Regional Carrier

DOH - Department of Health

Dual-eligible - individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

DRG - Diagnosis Related Grouper

DX - Diagnosis Code

EDI – Electronic Data Interchange

EOMB - Explanation of Medical Benefits

EPSDT – The Early and Periodic Screening, Diagnosis, and Treatment is a Medicaid initiative that provides preventative healthcare services for children.

ESA – Economic Security Administration (formerly known as Income Maintenance Administration), through an MOU with the Medicaid agency, has the responsibility to determine eligibility for all medical assistance programs. They also determine eligibility for SNAP, TANF, childcare subsidy, burial assistance and many more.

EVS – The Eligibility Verification System is a system to provide verification of beneficiary eligibility through telephone inquiry by the provider, using the DCID number.

FFP – Federal Financial Participation: The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures. **FQHC** – Federally Qualified Health Center

HBX – Health Benefits Exchange: the entity that administers and oversees the online marketplace for District residents and small businesses to enroll in private or public health insurance options. The District's Health Benefit Exchange will allow individuals and small businesses to compare health plans, to learn if they are eligible for tax credits for private insurance or health programs like DC Healthy Families/Medicaid, and to enroll in a health plan that meets their needs.

HCFA - Health Care Finance Administration

HCPCS - Healthcare Common Procedure Coding System

ICD-CM - International Classification of Diseases Clinical Modification

ICP – Immigrant Children's Program is a health program designed as a safety net for children under the age of 21 who do not meet the citizenship/immigration status requirements for Medicaid.

IMD – Intermediate Mental Disorder

IVR – The Interactive Voice Response Verification system is a system to provide verification of beneficiary eligibility, checking claim status through telephone inquiry by the provider, using the DCID number or Social Security Number (SSN)

LTAC - Long Term Acute Care

MAGI – Modified Adjusted Gross Income is a methodology for how income is counted and how household composition and family size are determined.

Managed Care Organization - Program to improve access to primary and preventive services where eligible beneficiaries shall be required to select a primary care provider who will be responsible for coordinating the beneficiary's care. Payment for services shall be on a capitated basis for prepaid plans. **Medicaid** - The District of Columbia's medical assistance program, provided under a state plan which has been approved by the U.S. Department of Health and Human Services under Title XIX of the Social Security Act.

Medicaid Benefits Package - All health services to which beneficiaries are entitled under the District of Columbia Medicaid program, except service in a skilled nursing facility, an institution for mental diseases and other services specifically excluded in the contract.

Medically Necessary - Description of a medical service or supply for the prevention, diagnosis, or treatment which is (1) consistent with illness, injury, or condition of the enrollee; (2) in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality

NCCI – National Correct Coding Initiative

NDC - National Drug Code Non-Compensable Item - Any service a provider supplies for which there is no provision for payment under Medicaid regulations.

NPI - National Provider Identifier is a 10-digit number that uniquely identifies a healthcare provider. Providers must apply for a NPI through NPPES.

NPPES – National Plan and Provider Enumeration System

Open Enrollment Period - The 30-day period following the date the beneficiary is certified or re-certified for the District's Medicaid Program. During this period, a beneficiary eligible to be covered under the managed care Program may select a provider without restrictions.

Prior Authorization (PA) - The approval of a service before it is provided, but it does not necessarily.

QMB – Qualified Medicare Beneficiary

RA – The Remittance Advice is a document sent to providers to report the status of submitted claims - paid, denied, and pended from Conduent.

Rejected - A term that describes a claim that has ***not*** met processing requirements.

RTP - Return to Provider

RTP Letter - A letter that accompanies a rejected claim that is sent to providers with an explanation identifying the reason for the return.

Specialist - An enrolled Medicaid physician whose practice is limited to a particular area of medicine including one whom, by virtue of advance training, is certified by a specialty board.

State Plan - The State Plan of Medical Assistance, which describes the eligibility criteria, services covered payment methodology and/or rates and any limitations approved by the Centers for Medicaid and Medicare Services for coverage under the District of Columbia's Medicaid Program.

TANF - The categorical eligibility designation for individuals who are eligible for Medicaid by they are eligible for cash assistance from the Temporary Assistance for Needy Families (TANF) program.

TCN - The unique transaction control number that is assigned to each claim for identification.

Third-Party Liability - Medical insurance, other coverage, or sources, which have primary responsibility for payment of health, care services on behalf of a Medicaid-eligible beneficiary.

UB04 – A revised version of the Universal Billing Form UB92 used by institutional providers.

Waiver - A situation where CMS allows the district to provide services that are outside the scope of the approved State Plan services, in non-traditional settings, and/or to beneficiaries not generally covered by Medicaid.