Claim Filing Instructions
October 2019
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Claim filing
Select Health of South Carolina’s (Select Health’s) First Choice Health plan, hereafter referred to as the plan, is required by state and federal regulations to capture specific data regarding services rendered to its members. Plan providers must adhere to all billing requirements to ensure timely processing of claims. In most cases, Select Health follows Medicaid billing requirements.

As a condition of participation in the Medicaid program, providers are required to maintain and provide immediate access to original and electronic medical records, including associated audit trails. A record is any document or electronically stored information, including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record.

Records are considered to be maintained when:

• They fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries.
• All required documentation is present in beneficiaries’ records before the provider files claims for reimbursement, unless program policy otherwise states.
• Beneficiary medical, fiscal, and other required records and supporting documentation are legible.

(South Carolina Department of Health and Human Services [SCDHHHS] Provider Administrative and Billing Manual).

Broken, missed, or canceled appointments
The Centers for Medicare & Medicaid Services (CMS) prohibits billing Medicaid members for broken, missed, or canceled appointments. Medicaid programs are state-designed and administered with federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency’s payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business (SCDHHHS Physicians Services Provider Manual).

National Correct Coding Initiative (NCCI)
In accordance with the South Carolina Medicaid program, Select Health uses NCCI edits and its related coding policy to control improper coding. CMS developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI edits are to prevent improper payment when incorrect code combinations or units of service are reported that exceed what is normally considered medically necessary. NCCI edits identify procedures and services performed by the same provider for the same member on the same date of service.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Services denied based on NCCI code pair edits or medically unlikely edits may not be billed to patients.

The medicaid.gov webpage [www.medicaid.gov/medicaid/program-integrity/ncci/index.html](http://www.medicaid.gov/medicaid/program-integrity/ncci/index.html) provides overview information to providers on Medicaid’s NCCI edits. Additional information can be found in the SCDHHHS Provider Administrative and Billing Manual.

Procedures for claim submission
Claims for billable services provided to plan members must be submitted by the provider or an entity employed by the provider who performs the services.

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

• Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
• Verification that all diagnosis and procedure codes are valid for the date of service.
• Verification for electronic claims against 837 edits at our clearinghouse, Change Healthcare (formerly known as Edeon).
• Verification of member eligibility for services under the plan during the time period in which services were provided.
• Verification that the services were provided by a participating provider or that the out-of-network provider has received authorization to provide services to the eligible member.
• Verification that the provider is eligible to participate with the Medicaid program at the time of service.
• Verification that the plan has authorized services that require prior plan authorization.
• Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that the plan is the “payer of last resort” on all claims submitted to the plan.

When required data elements are missing or invalid, claims will be rejected by the plan for correction and resubmission.

Denied claims are registered in the claim processing system, but do not meet requirements for payment under plan guidelines. They should be resubmitted as a corrected claim. Set claim frequency code correctly and send the original claim number. These are required elements and the claim will be rejected if not coded correctly. This applies to claims submitted on paper and electronically. Denied claims must be resubmitted as corrected claims within 365 calendar days from the date of service.

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

Corrected claims are defined as a resubmission of a previously processed claim due to a specific change, such as changes to CPT codes, diagnosis codes, or billed amounts. It is not a request to review the processing of a claim. Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original claim number.
Claim filing format

To ensure timely processing of claims, the correct information must be provided in the designated claim fields.

For professional services submitted on the CMS 1500 (02-12) claim form:
- Correct member name and First Choice member ID number or Healthy Connections ID number.
- Prior authorization number in box 23 on CMS 1500 form (if applicable).
- Clinical Laboratory Improvement Amendments (CLIA) identification number for lab testing in box 23 in lieu of prior authorization number, if applicable.
- National Drug Code (NDC) number in box 24A (if applicable).
- The individual provider National Provider Identifier (NPI) number in box 24.
- The service location information in box 32, NPI in box 32a, and taxonomy in box 32b.
- The payee information in box 33, NPI in box 33a, and taxonomy code in box 33b.

For hospital services submitted on the UB-04 claim form:
- NPI number in box 56.
- Prior authorization number in box 63 (if applicable).
- Valid revenue, diagnosis, and CPT codes when applicable. (Some providers inadvertently submit codes not recognized by South Carolina Healthy Connections Medicaid.)
- Taxonomy number in box 81.

Paper claims must include all applicable NPI numbers. Claims improperly or incorrectly submitted may be returned. If you have any questions, call the Provider Contact Center at 1-800-575-0418.

Claim submission instructions

Mail
Submit paper claims to Select Health of South Carolina at:
Select Health of South Carolina
Attn: Claim Processing Department
P.O. Box 7120
London, KY 40742

Electronic

The plan encourages all providers to submit claims electronically. If you are interested in electronic claim filing, contact your practice management software vendor, EDI software vendor, or the Change Healthcare (formerly Emdeon) Provider Support Line at 1-800-845-6592.

Note: Select Health’s plan EDI Payer ID number is 23285.

Any additional questions may be directed to the Provider Contact Center at 1-800-575-0418 or to Select Health’s Network Operations department at 1-800-741-6605.

Requests for adjustments/corrections

Requests for adjustments/corrections may be submitted electronically, on paper, or by phone.

Electronic

Please enter claim frequency codes “7” or “8” and use CLM05-3 to report claim adjustments electronically.

Always include the original claim number in segment REF01=F8 and REF02=the 13-digit original claim number; no dashes or spaces.

On paper

- Enter the resubmission code (7 or 8) in box 22 on the CMS1500 claim form.
- Include the original claim number following the resubmission code in the original reference number field.
- Do NOT write corrected or resubmission on the claim form.
- Make corrections to affected claim line(s) and submit all service lines that were on the original claim.
- Corrected claims submitted without this information will be rejected.

Submit claims to:
Select Health of South Carolina
Attn: Claim Processing Department
P.O. Box 7120
London, KY 40742

By phone

Contact the Provider Contact Center at 1-800-575-0418.

Select the prompts for the correct plan and then select the prompt for claim issues.

Administrative and medical necessity appeals

Administrative and medical necessity appeals must be submitted in writing to:
Select Health of South Carolina
Attn: Member Appeals
P.O. Box 40849
Charleston, SC 29423-0849

Pharmacy appeals are submitted to this same address. Health care professionals submitting appeals on the behalf of a member (with the member’s written consent) must file the appeal within 60 calendar days of receipt of the denial or adverse benefit determination notification.

Refer to the Health Care Professionals and Providers Manual online in the to arrange transmission.
Claim disputes
If a claim or a portion of a claim is denied for any reason or underpaid, health care professionals may submit a dispute within 60 calendar days of receipt of the adverse benefit determination notification.

Disputes may be submitted verbally or in writing:
- By calling the Provider Contact Center at 1-800-575-0418.
- Via fax at 1-844-249-9841.
- By contacting the account executive in your area.
- Via mail by sending correspondence to:
  Select Health of South Carolina
  Provider Claims Disputes
  P.O. Box 7310
  London, KY 40742-7310

Refer to the Health Care Professionals and Providers Manual online in the Provider section of the Select Health website at www.selecthealthofsc.com for more information on submitting disputes.

Claim Inquiries
An inquiry is a question from providers regarding how a claim was paid. Inquiries may be made via phone, NaviNet inquiry, or written correspondence. An inquiry may or may not result in a change in the payment.

You may initiate a claims inquiry via NaviNet with the claims adjustment inquiry function. Inquiries may also be submitted by phone to the Provider Contact Center at 1-800-575-0418. (Select the prompts for the correct Plan, and then select the prompt for claim issues.) If submitting via paper or NaviNet, please include the original claim number.

If you prefer to write, please address the letter to:
Select Health of South Carolina
Attn: Claims Processing Department
P.O. Box 7120 London, KY 40742-7120

Claim filing deadlines
All original paper and electronic claims must be submitted to the plan within 365 calendar days from the date services were rendered or compensable items were provided (or the date of discharge for inpatient admissions). Please allow for normal processing time (30 days for clean claims) before resubmitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Resubmit previously denied claims with corrections and requests for adjustments within 365 days from the date services were rendered or compensable items were provided.

Deadline exceptions
Claims with explanations of benefits (EOBs) from primary insurers, including Medicare, must be submitted within 60 days of the date of the primary insurer’s EOB (showing claim adjudication). This exception applies when the claim cannot be submitted within 365 days of the date of service due to the involvement of a primary insurer.

Refunds for claim overpayments or errors
The plan and South Carolina Department of Health and Human Services (SCDHHS) encourage providers to conduct regular self-audits to ensure accurate payment.

Medicaid program funds that were improperly paid or overpaid must be returned. If a provider determines that an overpayment or improper payment has been received, the provider is required to return the funds to Select Health within 60 days from the date of discovery of the overpayment or improper payment.

There are two ways to return overpayments:
- Complete the Provider Claim Refund form on the Select Health website at www.selecthealthofsc.com/provider/resources/forms.aspx and have the plan deduct the overpayment or improper payment amount from future claims payments. Send the completed form without a refund check to:
  Cost Containment Department
  P.O. Box 7320
  London, KY 40742
- Submit a completed Provider Refund Claim form and a refund check for the overpayment or improper payment amount directly to:
  Select Health of South Carolina
  Attn: Claims Repayment Research Unit
  P.O. Box 7120
  London, KY 40742

Claim form field requirements
The following charts describe the fields that must be completed for the standard Centers for Medicare & Medicaid Services (CMS) CMS 1500 and UB-04 claim forms. A sample of each form can be found in the exhibits.

If the field is required without exception, an “R” (required) is noted in the Required or Conditional box.

If completing the field depends on certain circumstances, the requirement is listed as “C” (conditional), and the relevant conditions are...
explained in the Instructions and Comments box.

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. Refer to the NUCC or NUCB reference manuals for additional information.

All claims must be submitted within the required filing deadline of 365 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

Claims with explanations of benefits (EOBs) from primary insurers, including Medicare, must be submitted within 60 days of the date on the primary insurer’s EOB. This exception applies when the claim cannot be submitted within 365 days of the date of service due to the involvement of a primary insurer.

Claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

### CMS 1500 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
</table>
| N/A          | Carrier Block     | Enter in the white, open carrier area the name and address of the payer to whom this claim is being sent. Enter the name and address information in the following format:  
  • First line: Name  
  • Second line: First line of address  
  • Third line: Second line of address, if necessary  
  • Fourth line: City, state (two characters) and ZIP code | | 2010BB | NM103 | For an address with three lines, enter it in the following format:  
  • First line: Name  
  • Second line: Line of address  
  • Third line: Leave blank  
  • Fourth line: City, state (two characters) and ZIP code |
| 1            | Insurance Program Identification | Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. | | 20000 | SBP09 | Titled Claim Filing Indicator in the 837P. |
| 1a           | Insured's ID Number | Enter the member ID number. For electronic submissions, this ID must be fewer than 17 alphanumeric characters. | | 2010BA | NM109 | Titled Subscriber Primary Identifier in the 837P. |
| 2            | Patient's Name (last, first, middle initial) | Enter the patient’s name as it appears on the member ID card or enter the newborn’s name when the patient is a newborn. | | 2010CA or 2010BA | NM103, NM104, NM105, NM106, NM107 | |
| 3            | Patient's Birth Date and Sex | Enter the patient’s eight-digit birth date and select the appropriate gender. | | 2010CA or 2010BA | CMS02, CMS03 | Sex is titled Gender in the 837P. |
| 4            | Insured's Name (last, first, middle initial) | Enter the patient’s name as it appears on the member ID card, or enter the newborn’s name when the patient is a newborn. | | 2010BA | NM103, NM104, NM105, NM106, NM107 | Titled Subscriber in the 837P. |
| 5            | Patient's Address (number, street, city, state, ZIP code) Phone (with area code) | Enter the patient’s complete address and phone number. (Do not punctuate the address or phone number.) | | 2010CA | NM101, NM102, NM103, NM104 | |
| 6            | Patient Relationship to Insured | Always indicate self. | | 20000 | SBP02, PATG01 | Titled Individual Relationship Code in the 837P. |
| 7            | Insured's Address (number, street, city, state, ZIP code) Phone (with area code) | If same as the patient, enter “Same.” | | 2010BA | NM101, NM102, NM103, NM104, NM105, NM106, NM107 | Titled Subscriber Address in the 837P. |
| 8            | Reserved for National Uniform Claim Committee (NUCC) use (previously titled Patient Status) | Not used. | | N/A | | Patient Status does not exist in the 837P. |
### CMS 1500 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional*</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Other Insured’s Name (last, first, middle initial)</td>
<td>Refers to someone other than the claimant. Completion of fields 9a and 9d is required if the patient is covered by another insurance plan. Enter the complete name of the insured.</td>
<td>C</td>
<td>2330A</td>
<td>N103</td>
<td>Titled Other Subscriber Name in the 837P.</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
<td>Required if 9 is completed.</td>
<td>C</td>
<td>2320</td>
<td>SBR03</td>
<td>Titled Group or Policy Number in the 837P.</td>
</tr>
<tr>
<td>9b</td>
<td>Reserved for NUCC use</td>
<td>To be determined.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Does not exist in the 837P.</td>
</tr>
<tr>
<td>9c</td>
<td>Reserved for NUCC use</td>
<td>To be determined.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Does not exist in the 837P.</td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Required if 9 is completed. List name of other health plan, if applicable. Required if other insurance is available. Complete if more than one other Medical insurance is available or if 9a is completed.</td>
<td>C</td>
<td>2320</td>
<td>SBR04</td>
<td>Titled Insurance Group Name in the 837P.</td>
</tr>
<tr>
<td>10a, 10b, 10c</td>
<td>Is Patient’s Condition Related to:</td>
<td>Indicate Yes or No for each category. Is the condition related to:</td>
<td>R</td>
<td>2300</td>
<td>CLM1</td>
<td>Titled Related Causes Code in the 837P.</td>
</tr>
<tr>
<td>10d</td>
<td>Claim Codes</td>
<td>Enter condition codes as appropriate. Available two-digit condition codes include nine codes for abortion services and four codes for workers’ compensation. Refer to the list of condition codes for abortion and workers’ compensation claims in the Appendix section of this manual. For workers’ compensation claims: Condition codes are required when submitting a bill that is a duplicate or an appeal. (The original reference number must be entered in Box 22 for these situations.) Note: Do not use condition codes when submitting a revised or corrected bill.</td>
<td>C</td>
<td>2300</td>
<td>HI</td>
<td>NTE</td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group or FECA Number</td>
<td>Enter the insureds policy or group number as it appears on the insured’s health care identification card, if applicable.</td>
<td>C</td>
<td>2300B</td>
<td>SBR03</td>
<td>Titled Subscriber Group Number in the 837P.</td>
</tr>
<tr>
<td>11a</td>
<td>Insured’s Birth Date and Sex</td>
<td>Enter the eight-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.</td>
<td>C</td>
<td>2010BA</td>
<td>DMG02</td>
<td>Titled Subscriber Birth Date and Subscriber Gender Code in the 837P.</td>
</tr>
<tr>
<td>11b</td>
<td>Other Claim ID (previously titled Insured’s Employer Name or School Name)</td>
<td>Enter the following qualifier and accompanying identifier (or claim number) to report the claim number assigned by the payer for workers’ compensation or property and casualty: Y4: Property casualty claim number. Enter qualifier to the left of the vertical dotted line; identifier to the right of the vertical dotted line.</td>
<td>C</td>
<td>2010BA</td>
<td>REPO1</td>
<td>REPO2</td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td>Enter name of the health plan. Required if 11 is completed.</td>
<td>C</td>
<td>2000B</td>
<td>SBR04</td>
<td>Titled Subscriber Group Name in the 837P.</td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td>Indicate Yes or No by checking the box. If Yes, complete 9a – 9d.</td>
<td>R</td>
<td>2320</td>
<td>CLM09</td>
<td>Titled Release of Information Code in the 837P.</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or Authorized Person’s Signature</td>
<td>Enter “Signature on File,” “SOF,” or legal signature. If there is no signature on file, leave blank or enter “No Signature on File.” Indicates that there is a signature on file authorizing payment of medical benefits.</td>
<td>R</td>
<td>2300</td>
<td>CLM8</td>
<td>Titled Benefit Assignment Certification in the 837P.</td>
</tr>
<tr>
<td>13</td>
<td>Insured’s or Authorized Person’s Signature</td>
<td>Enter “Signature on File,” “SOF,” or legal signature. If there is no signature on file, leave blank or enter “No Signature on File.”</td>
<td>C</td>
<td>2300</td>
<td>CLM8</td>
<td>Titled Benefit Assignment Certification in the 837P.</td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness, Injury, Pregnancy (LMP)</td>
<td>MMDDYY or MMDDYYYY Enter applicable three-digit qualifier to the right of the vertical dotted line. Qualifiers include:</td>
<td>C</td>
<td>2300</td>
<td>DTP01</td>
<td>DTP03</td>
</tr>
<tr>
<td>15</td>
<td>Other Date (previously if patient has same or similar illness)</td>
<td>MMDDYY or MMDDYYYY Enter applicable three-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include:</td>
<td>C</td>
<td>2300</td>
<td>DTP01</td>
<td>DTP03</td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td>The time span the patient is or was unable to work.</td>
<td>C</td>
<td>2300</td>
<td>DTP01</td>
<td>DTP03</td>
</tr>
</tbody>
</table>
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<th>Required or conditional*</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Name of Referring Physician or Other Source</td>
<td>Required if provider other than the member's primary care provider rendered invoiced services. Enter the applicable two-digit qualifier to the left of the 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: DN: Jane A Smith MD</td>
<td>C</td>
<td>2310A (Referring) 23100 (Supervising) 24208 (Ordering)</td>
<td>NMI01 NMI03 NMI04 NMI05 NMI107</td>
<td></td>
</tr>
<tr>
<td>17a</td>
<td>Other ID Number of Referring Physician</td>
<td>The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 37a. NUCC defines the following qualifiers used in 5010A1: • OB: State License Number. • LG: Provider URN Number. • G2: Provider Commercial Number. • LL: Location Number (This qualifier is used for supervising provider only). The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or the provider designated taxonomy code. Required if 17 is completed.</td>
<td>C</td>
<td>2310A (Referring) 23100 (Supervising) 24208 (Ordering)</td>
<td>REF01 REF02 Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in the 837P.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td>Required when place of service is inpatient: MMDDYY (indicate from and to date).</td>
<td>C</td>
<td>2300</td>
<td>DTP01 DTP03 Titled Related Hospitalization Admission Date and Related Discharge Date in the 837P.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Additional Claim Information (designated by NUCC)</td>
<td>For beneficiaries participating in special programs (e.g., certified long-term care, MCCW, hospice), enter the primary care provider's referral number.</td>
<td>Not required</td>
<td>2300</td>
<td>NTE P01X</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab</td>
<td>Optional Example: C</td>
<td>2400</td>
<td>PS102 Titled Purchased Service Charge Amount in the 837P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CMS 1500 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional*</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness or Injury, (Relate to 24E)</td>
<td>Enter the applicable ICD indicator to identify which version of ICD codes is being reported. • 3: ICD-10-CM. • Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. 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 2AE by the letter of the line. Use the highest specificity. Do not provide narrative description in this field.</td>
<td>R</td>
<td>2300</td>
<td>H01-2 H02-2 H03-2 H04-2 H05-2 H06-2 H07-2 H08-2 H09-2 H10-2 H11-2 H12-2</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Resubmission Code and/or Original Reference Number.</td>
<td>For resubmissions, enter the appropriate left or corrected claim frequency code (7 or 8 – see below) left-justified in the Submission Code section, and the claim ID number of the original claim in the Original Reference Number section of this field. This is required for corrected, resubmitted, or adjusted claims: • 7: Replacement of Prior Claim. • 8: Void/Cancel of Prior Claim.</td>
<td>C</td>
<td>2300</td>
<td>CLM05-3 REF02 Titled Claim Frequency Code in the 837P. Titled Payer Claim Control Number in the 837P. List the original reference number for resubmitted claims. (Resubmission means the code and original reference number assigned by the payer to indicate a previously submitted claim.)</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
<td>Enter the prior authorization number. Refer to the Provider Manual or the Select Health website: <a href="http://www.selecthealthsfc.com">www.selecthealthsfc.com</a> to determine if services rendered require an authorization.</td>
<td>C</td>
<td>2300</td>
<td>REF02 REF04-61 Titled Prior Authorization Number in the 837P is the payer assigned number authorizing the service(s).</td>
<td></td>
</tr>
<tr>
<td>24A</td>
<td>Date(s) of Service</td>
<td>See Paper CMS 1500 instructions and examples of supplemental information in item 24 section of this manual for guidance in the shaded portions of fields 24A – 24J. “From” date: MMDDYY. If the service was performed on one day there is no need to complete the “to” date. This field allows for the entry of the following in each of the unshaded date fields: two characters under MM, two characters under DD, and two characters under YY.</td>
<td>R</td>
<td>2400</td>
<td>DTP01 DTP03 Titled Service Date in the 837P.</td>
<td></td>
</tr>
</tbody>
</table>
### CMS 1500 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>24B</td>
<td><strong>Place of Service</strong></td>
<td>Enter the CMS standard place of service code: “00” for place of service is not acceptable.</td>
<td>R</td>
<td>2300</td>
<td>CLM05-1 SV105 Facility Code Value: Titled Facility Code Value in the 837P.</td>
<td>Place of Service Code: Titled Facility Code Value in the 837P.</td>
</tr>
<tr>
<td>24C</td>
<td><strong>EMG</strong></td>
<td>This is an emergency indicator field. Enter Y for “Yes” or leave blank for “No” in the bottom (unshaded area of the field).</td>
<td>C</td>
<td>2400</td>
<td>SV109</td>
<td>Emergency Indicator: Titled Facility Code Value in the 837P.</td>
</tr>
<tr>
<td>24D</td>
<td><strong>Procedures, Services, or Supplies CP/CPT/Healthcare Common Procedure Coding System (HCPCS)/Modifier</strong></td>
<td>Enter the CPT or HCPCS code(s) and modifier (if applicable). Procedure codes (up to five digits) and modifiers (two digits) must be valid for the date of service. Note: Modifiers affecting reimbursement must be placed in the first modifier position.</td>
<td>R</td>
<td>2400</td>
<td>SV101 (2-6) Titled Product/Service ID Code and Procedure Modifier in the 837P.</td>
<td>Diagnosis Pointer — Indicate the associated diagnosis by referencing the pointers listed in field 21 (A – L). Do not enter diagnosis codes in 24E. The plan can accept up to 12 diagnosis pointers in this field.</td>
</tr>
<tr>
<td>24E</td>
<td><strong>Diagnosis Pointer</strong></td>
<td>Diagnosis Pointer — Indicate the associated diagnosis by referencing the pointers listed in field 21 (A – L). Do not enter diagnosis codes in 24E. The plan can accept up to 12 diagnosis pointers in this field.</td>
<td>R</td>
<td>2400</td>
<td>SV107 (1-4) Alpha pointers (A – L) on the CMS 1500 claim form must be converted to numeric pointers (1–12) in the 837P. Titled Diagnostic Code Pointer in 837P.</td>
<td>Note: Modifiers affecting reimbursement must be placed in the first modifier position.</td>
</tr>
<tr>
<td>24F</td>
<td><strong>Charges</strong></td>
<td>Enter charges. A value must be entered. Enter zero ($0.00) or the actual charged amount. (This includes capitalized services.)</td>
<td>R</td>
<td>2400</td>
<td>SV102</td>
<td>Titled Line Item Charge Amount in the 837P.</td>
</tr>
<tr>
<td>24G</td>
<td><strong>Days or Units</strong></td>
<td>Enter quantity. Value entered must be greater than zero. (Field allows up to three digits.)</td>
<td>R</td>
<td>2400</td>
<td>SV104</td>
<td>Titled Service Unit Count in the 837P.</td>
</tr>
<tr>
<td>24H</td>
<td><strong>Child Health Check (EPSDT) Services</strong></td>
<td>In the shaded area of the field: - AV: Patient refused referral - S2: Patient is currently under treatment for referred diagnostic or corrective health problem - NU: No referral given, or - ST: Referral to another provider for diagnostic or corrective treatment.</td>
<td>C</td>
<td>2300</td>
<td>CRC SV111 SV112 Titled EPSDT indicator and Family Planning Indicator in the 837P.</td>
<td>If there is no requirement (e.g., state requirement) to report a reason code for EPSDT, enter Y for “yes” or N for “no” only.</td>
</tr>
<tr>
<td>24I</td>
<td><strong>ID Qualifier</strong></td>
<td>Enter the ID qualifier identifying the number in the shaded area of 24J if it is a non-HPI. The NUCC defines the following qualifiers: - OB: State License Number - 1G: Provider URN Number. - G2: Plan-Assigned Provider Number. - LU: Location Number. - ZZ: Provider Taxonomy.</td>
<td>R</td>
<td>2301B</td>
<td>NMI08 RE01 Titled Reference Identification Qualifier in the 837P.</td>
<td>The other ID Number of the rendering provider should be reported in 24J in the shaded area.</td>
</tr>
</tbody>
</table>

### CMS 1500 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>24J</td>
<td><strong>Rendering Provider ID Number</strong> (shaded portion)</td>
<td>The individual rendering the service is reported in 24J. Enter the Select Health provider ID number in the shaded area of the field. Change HealthCare will pass this ID on when present.</td>
<td>Not required</td>
<td>2310B</td>
<td>RE02</td>
<td>Titled Rendering Provider Identification Qualifier/Secondary Identifier in the 837P.</td>
</tr>
<tr>
<td>24J</td>
<td><strong>Rendering Provider NPI</strong> (in the bottom unshaded portion)</td>
<td>The individual rendering the service is reported in 24J. Enter the NPI number in the unshaded area of the field.</td>
<td>R</td>
<td>2310B</td>
<td>NM109</td>
<td>Titled Rendering Provider Identifier (NPI) in the 837P.</td>
</tr>
<tr>
<td>25</td>
<td><strong>Federal Tax ID Number SSN/EIN</strong></td>
<td>Provider or supplier’s federal tax ID (employer ID or SSN) number.</td>
<td>R</td>
<td>2010AA</td>
<td>RE01</td>
<td>Titled Reference Identification Qualifier and Billing Provider TIN in the 837P.</td>
</tr>
<tr>
<td>26</td>
<td><strong>Patient’s Account Number</strong></td>
<td>Enter the patient’s account number assigned by the provider.</td>
<td>R</td>
<td>2300</td>
<td>CLM01</td>
<td>Titled Patient Control Number in the 837P.</td>
</tr>
<tr>
<td>27</td>
<td><strong>Accept Assignment</strong></td>
<td>Yes or No must be checked.</td>
<td>R</td>
<td>2300</td>
<td>CLM07</td>
<td>Titled Assignment or Plan Participation code in the 837P.</td>
</tr>
<tr>
<td>28</td>
<td><strong>Total Charge</strong></td>
<td>Enter the total of all charges listed on the claim.</td>
<td>R</td>
<td>2300</td>
<td>CLM02</td>
<td>Titled Total Claim Charge Amount in the 837P.</td>
</tr>
<tr>
<td>29</td>
<td><strong>Amount Paid</strong></td>
<td>Enter the total amount the patient and/or other payers paid on the covered services. Required when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the plan. Medicaid programs are always the payers of last resort.</td>
<td>C</td>
<td>2300</td>
<td>AMT02</td>
<td>Titled Patient Amount Paid in the 837P.</td>
</tr>
<tr>
<td>30</td>
<td><strong>Reserved for NUC/C use</strong></td>
<td>To be determined.</td>
<td>Not required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td><strong>Signature of Physician or Supplier, Including Degrees and Credentials/Date</strong></td>
<td>Signature on file, signature stamp, or computer generated or actual signature is acceptable.</td>
<td>R</td>
<td>2300</td>
<td>CLM06</td>
<td>Titled Provider or Supplier Signature Indicator in the 837P.</td>
</tr>
<tr>
<td>32</td>
<td><strong>Name and Address of Facility Where Services Were Rendered</strong></td>
<td>Enter the physical location. (P.O. box numbers are not acceptable here.)</td>
<td>R</td>
<td>2310C</td>
<td>NMI03 N501 N502 N503</td>
<td>Titled Rendering Provider NPI in the 837P.</td>
</tr>
</tbody>
</table>
### CMS 1500 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>32a NPI Number</td>
<td>Enter the NPI number of the service facility location.</td>
<td></td>
<td>Required unless rendering provider is an atypical provider and is not required to have an NPI number. OR Service facility location NPI is the same as the billing provider NPI.</td>
<td>R</td>
<td>2310C</td>
<td>NM109</td>
</tr>
<tr>
<td>32b Other ID Number</td>
<td>The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility. The NUCC defines the following qualifiers: • 0B: State License Number. • G2: Provider Commercial Number. • LU: Location Number.</td>
<td></td>
<td>Recommended</td>
<td>C</td>
<td>2310C</td>
<td>REF01 REF02</td>
</tr>
<tr>
<td>33 Billing Provider Information and Phone Number</td>
<td>Required — Identifies the provider requesting to be paid for the services rendered and should always be completed. Enter physical location; P.O. boxes are not acceptable. • First line: Name. • Second line: Address. • Third line: City, state, and nine-digit ZIP code.</td>
<td>Do not use punctuation (e.g., commas, periods) or other symbols in the address.</td>
<td>Required</td>
<td>R</td>
<td>2010AA</td>
<td>NM103 NM104 NM105 NM107 N301 N401 N402 N403 N404</td>
</tr>
<tr>
<td>33a NPI Number</td>
<td>Required unless rendering provider is an atypical provider and is not required to have an NPI number.</td>
<td></td>
<td>Required</td>
<td>R</td>
<td>2010AA</td>
<td>NM109</td>
</tr>
<tr>
<td>33b Other ID Number</td>
<td>Required when the billing provider is an atypical provider and does not have an NPI number.</td>
<td>If using NPI in field 33a, enter the taxonomy code in 33b and the qualifier “ZZ” in the box to the left. The NUCC defines the following qualifiers: • 0B: State License Number. • G2: Provider Commercial Number. • ZZ: Provider Taxonomy.</td>
<td>Recommended</td>
<td>C</td>
<td>2000A 2010AA</td>
<td>PRV03 REF01 REF02</td>
</tr>
</tbody>
</table>

### Paper CMS 1500 instructions and examples of supplemental information in item 24

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

- Anesthesia duration in hours and/or minutes with start and end times.
- Narrative description of unspecified codes.
- National Drug Codes (NDCs) for drugs (see next section for more information).
- Vendor Product Number — Health Industry Business Communications Council (HIBCC).
- Product Number Health Care Uniform Code Council — Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products.
- Product Code (UPC) for products formerly universal.
- Contract rate.

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

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Anesthesia information</td>
</tr>
<tr>
<td>ZZ</td>
<td>Narrative description of unspecified code (all miscellaneous fields require this section be reported)</td>
</tr>
<tr>
<td>N4</td>
<td>NDCs</td>
</tr>
<tr>
<td>VP</td>
<td>Vendor product number: Health Industry Business Communications Council (HIBCC)</td>
</tr>
<tr>
<td>OZ</td>
<td>Product number Health Care Uniform Code Council: Global Trade Item Number (GTIN)</td>
</tr>
<tr>
<td>CTR</td>
<td>Contract rate</td>
</tr>
</tbody>
</table>

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

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and the number, code, and information at 24A. After the first item, enter three blank spaces and then the next qualifier and number, code, and information.
Paper CMS 1500 National Drug Codes (NDCs)

- NDCs must be entered in the shaded sections of items 24A through 24G.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11-digit NDC information.
- Do not enter a space between the qualifier and the 11-digit NDC number.
- Enter the 11-digit NDC number in the 5-4-2 format (no hyphens). Do not submit any other information on the line with the NDC.
- Drug name and strength should not be included on the line with the NDC.
- Do not use 99999999999 for a compound medication. Bill each drug as a separate line item with its appropriate NDC.
- Enter the drug name and strength.
- Enter the NDC quantity unit qualifier:

<table>
<thead>
<tr>
<th>NDC quantity unit qualifier</th>
<th>Unit of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>F2</td>
<td>International unit</td>
</tr>
<tr>
<td>GR</td>
<td>Gram</td>
</tr>
<tr>
<td>ML</td>
<td>Milliliter</td>
</tr>
<tr>
<td>UN</td>
<td>Unit</td>
</tr>
</tbody>
</table>

- Enter the NDC quantity.
- Do not use a space between the NDC quantity unit qualifier and the NDC quantity.

Note: The NDC quantity is frequently different than the HCPC code quantity.

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

```
N4 qualifier
10
15
12
11
15
12
11
J1885

Drug name and strength
KETORLAC 15MG/ML SYRING

NDC quantity
11-digit NDC number
ML2
```

Electronic data interchange (EDI) CMS 1500 instructions and examples of supplemental information in item 24

**EDI — field 24D (professional)**

Details pertaining to EPSDT, anesthesia minutes and corrected claims may be sent in notes (NTE) or remarks (NSF format).

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

**EDI CMS 1500 other instructions**

**EDI — field 33b (professional)**

- Field 33b — other ID number — professional: 2310B loop, REF01-G2, REF02 + the plan’s provider network number.
- This field holds fewer than 13 digits — alphanumeric.
- Field is required.
- Note: Do not send the provider on the 2400 loop. This loop is not used in determining the provider ID on the claims.

**EDI — fields 45 and 51 (institutional)**

- Field 45 — Service date must not be earlier than the claim statement date.
- Service line loop 2400, DTP*472.
- Claim statement date loop 2300, DTP*434.
- Field 51 — health plan ID — the number used by the health plan to identify itself.
- The Select Health plan EDI payer ID number is 23285.

**EDI — reporting DME**

- DME claims requiring specific instructions should begin with the letters “DME” followed by details.
- Example: NTE*ADD*DME AEROSOL MASK, USED With DME NEBULIZER.
EDI CMS 1500 NDCs

The NDC is required for all drugs and biologicals supplied, including physician-administered injectables. Continue to report NDC in the LIN segment of loop ID-2410. This segment is used to specify billing and reporting for drugs provided that may be part of the service(s) described in SV1.

- When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits with no hyphens. Submit one occurrence of the LIN segment per claim line. Claims requiring multiple NDCs sent at claim line level should be submitted using a CMS 1500 or UB-04 paper claim.
- When submitting an NDC in the LIN segment, the CTP segment is required. This segment is to be submitted with the unit of measure and the quantity.
- When submitting this segment, CTP03 (pricing), CTP04 (quantity), and CTP05 (unit of measure) are required.

Corrected CMS 1500 claims via EDI

- Use “7” for corrected/replacement claims, “8” to void or cancel a prior claim in loop 2300, CLM05-03 (837P).
- Include the original claim number in segment REF01=F8 and REF02=the 13-digit original claim number with no dashes or spaces.
- Do use this indicator for claims that were previously processed (approved or denied).
- Do not use this indicator for claims that contained errors and were not processed (rejected up front).
- Do not submit corrected claims electronically and via paper at the same time.

EDC claims with NDC information should be sent using the 2410 loop line segment. If not submitting in X12 format, please consult your EDI vendor for details on where to submit the NDC number to meet this specification.

UB-04 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional*</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unlabeled field</td>
<td>Service location, no P.O. boxes.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>R R</td>
<td>2010AA</td>
<td>N4*85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Left-justified.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Line a: Enter the complete provider name.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Line b: Enter the complete address.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Line c: Enter city, state, and ZIP code + four digits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Line d: Enter the area code and phone number.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Unlabeled field</td>
<td>Billing provider’s designated pay-to address (remit).</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>R R</td>
<td>2010AB</td>
<td>N4*87</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Billing provider’s designated pay-to address (remit).</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>R R</td>
<td>2010AB</td>
<td>N4*87</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Control Number</td>
<td>Provider’s patient account/ control number.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>R R</td>
<td>2300</td>
<td>CLM01</td>
</tr>
<tr>
<td>3b</td>
<td>Medical/ Health Record Number</td>
<td>The number assigned to the patient’s medical/health record by the provider.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>C C</td>
<td>2300</td>
<td>REF*EA/02</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>Enter the appropriate three- or four-digit code.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>R R</td>
<td>2300</td>
<td>CLM05 1/2/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>First position: Indicates the type of facility.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Second position: Indicates the type of care.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Third position: Indicates the billing sequence.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax Number</td>
<td>Enter the number assigned by the federal government for tax reporting purposes.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>R R</td>
<td>2010AA</td>
<td>REF, where REF01 = EI</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period From/Through</td>
<td>Enter dates in the format MMDDYY for the full range of services being invoiced.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>R R</td>
<td>2300</td>
<td>DTP03 where DTP01 = 434</td>
</tr>
<tr>
<td>7</td>
<td>Unlabeled field</td>
<td>No entry required.</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>8a</td>
<td>Patient Identifier</td>
<td>If patient = subscriber</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>C C</td>
<td>2010BA</td>
<td>NM109 where NM101 = L</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If patient not = subscriber</td>
<td>1/2/3/4/5/6/7/8/9</td>
<td>C C</td>
<td>2010CA</td>
<td>NM109 where NM101 = Q</td>
</tr>
</tbody>
</table>

Select Health of South Carolina Claim Filing Manual
### UB-04 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8b</td>
<td>Patient Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If patient = subscriber</td>
<td></td>
<td>Patient name is required. Last name, first name, and middle initial are required. Enter the patient name as it appears on the Select Health ID card.</td>
<td></td>
</tr>
<tr>
<td>If patient not = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9a – 9e</td>
<td>Patient Address</td>
<td>The mailing address of the patient. Separate the last and first names. If the patient is a newborn, indicate the baby’s name and gender. For newborns and multiple births, indicate the birth order in the patient name field. For example: Baby Girl Smith A, Baby Girl Smith B.</td>
<td></td>
</tr>
<tr>
<td>If patient = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If patient not = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9f</td>
<td>Patient Name</td>
<td>If patient = subscriber</td>
<td>Place in order: Suffix, prefix, last name, first name, middle initial. Suffix and middle initial should not be reported.</td>
</tr>
<tr>
<td>If patient not = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Patient Birth Date</td>
<td>The date of birth of the patient.</td>
<td></td>
</tr>
<tr>
<td>If patient = subscriber</td>
<td></td>
<td>Right-justified, using format MMDDYYYY</td>
<td></td>
</tr>
<tr>
<td>If patient not = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Patient Sex</td>
<td>The sex of the patient recorded at admission. For newborns, the sex of the baby is recorded. If a newborn is a single birth, baby’s first name is required. For a child of a newborn, the appropriate last name is recorded for the mother and baby. On claims for twins or other multiple births, indicate the birth order in the patient name field. For example: Baby Girl Smith A, Baby Girl Smith B.</td>
<td></td>
</tr>
<tr>
<td>If patient = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If patient not = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>Date of the admission or start of care.</td>
<td></td>
</tr>
<tr>
<td>If patient = subscriber</td>
<td></td>
<td>Right-justified, using format MMDDYYYY</td>
<td>Right-justified.</td>
</tr>
<tr>
<td>If patient not = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour</td>
<td>Admission hour.</td>
<td></td>
</tr>
<tr>
<td>If patient = subscriber</td>
<td></td>
<td>For bill types: Inpatient, Outpatient, and Conditional*</td>
<td></td>
</tr>
<tr>
<td>If patient not = subscriber</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### UB-04 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Priority Type</td>
<td>Type of admission.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>SRC Source of Admission</td>
<td>Front of origin for admission or visit.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>DHR Discharge Hour</td>
<td>Discharge hour from inpatient care.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>STAT Patient Discharge Status</td>
<td>Code indicating the disposition or discharge status of the patient at the end of the service period on the bill.</td>
<td></td>
</tr>
<tr>
<td>18 – 28*</td>
<td>Condition Codes</td>
<td>Code identifying conditions or events relating to the bill that may affect processing.</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>ACDT State: Accident Status</td>
<td>If services are related to an auto accident, enter the two-digit state or province abbreviation where the accident occurred.</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Unlabeled field</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 – 34</td>
<td>Occurrence Codes/Date</td>
<td>Events related to billing period, including dates.</td>
<td></td>
</tr>
<tr>
<td>35 – 36</td>
<td>Occurrence Span</td>
<td>Occurrence span codes and dates that identify an event that relates to the payment of the claim.</td>
<td></td>
</tr>
</tbody>
</table>

*Condition codes for Medicare eligible nursing facilities: Condition codes should be billed when Medicare Part A does not cover nursing facility services applicable condition codes: X2 – Medicare EOMB on File X4 – Medicare Denial on File

When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed:

Condition codes: Enter condition code X2 or X4 when one of the following criteria is applicable to the nursing facility service for which you are billing:

- There was no 3-day prior hospital stay.
- The resident was not transferred within 30 days of a hospital discharge.
- The resident’s 100 benefit days are exhausted.
- There was no 60-day break in daily skilled care.
- Medical necessity requirements are not met.
- Daily skilled care requirements are not met.

All other fields must be completed per the appropriate billing guide.
### UB-04 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional* (repeatable) Layout types</th>
<th>Required or conditional* Unique Layout types</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>Unlabeled field</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>38</td>
<td>Responsible Party</td>
<td>Name and address of the party responsible for the bill.</td>
<td>C C</td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>39 – 41</td>
<td>Value Code/Amount</td>
<td>Value codes and amounts.</td>
<td>C C</td>
<td>C 2300</td>
<td></td>
<td>HX0-2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HX0-5</td>
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<tr>
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<td></td>
<td>HX0-1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>01-12</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>Lines 1 – 22: Enter the appropriate three-digit review code. Line 23: Enter the bill creation date and total billed.</td>
<td>R R</td>
<td>2400</td>
<td>SV201</td>
<td>BHT</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Revenue Description</td>
<td>Standard abbreviated description of the related revenue code category.</td>
<td>C C</td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/HCPCS/HPPCS</td>
<td>Enter the applicable code.</td>
<td>R R</td>
<td>2400</td>
<td>SV202</td>
<td>JHC/HP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code</td>
<td>HCPCS are required for all outpatient claims and NDC numbers are required for physician administered drugs.</td>
<td></td>
<td></td>
<td></td>
<td>S2-1</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>SERV:Service Dates</td>
<td>Line item dates for service for each revenue category.</td>
<td>R R</td>
<td>2400</td>
<td>CTP03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Service/Units</td>
<td>Quantitative measure of services rendered for each revenue category. For drugs, service units must be consistent with the NDC code and its unit of measure. The NDC unit of measure must be a valid Health Insurance Portability and Accountability Act (HIPAA) unit of measure (UOM) code or the claim may be rejected.</td>
<td>R R</td>
<td>2400</td>
<td>SV205</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>Total of charges (covered and noncovered) for this billing statement.</td>
<td>R R</td>
<td>2300</td>
<td>SV203</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### UB-04 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional* (repeatable) Layout types</th>
<th>Required or conditional* Unique Layout types</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>Noncovered Charges</td>
<td>The noncovered charges for the destination payer for the related revenue code.</td>
<td>C C</td>
<td></td>
<td></td>
<td>S2/07</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Unlabeled field</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>50A – 50C</td>
<td>Payer Name</td>
<td>For each payer being insured.</td>
<td>a. Primary insurance. b. Secondary insurance. c. Tertiary insurance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Health Plan Number</td>
<td>Health plan payer ID. Select health plan payer ID is 032885.</td>
<td>R R</td>
<td>2010BB</td>
<td></td>
<td>2300B</td>
<td>032885</td>
</tr>
<tr>
<td></td>
<td>Identification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F01</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Release of Information</td>
<td>Release of information certification indicator.</td>
<td>R R</td>
<td>2300B</td>
<td></td>
<td>CLM09</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Assignment of Benefits</td>
<td>Assignment of benefits certification. Valid entries are &quot;Y&quot; (yes) and &quot;N&quot; (no).</td>
<td>R R</td>
<td>2300B</td>
<td></td>
<td>CLM08</td>
<td></td>
</tr>
<tr>
<td>54A – 54C</td>
<td>Prior Payments</td>
<td>Payments made by payer in field 50.</td>
<td>C C</td>
<td>2300B</td>
<td></td>
<td>AMT02</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMT02</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMT01+0</td>
<td></td>
</tr>
<tr>
<td>55A – 55C</td>
<td>Estimated Amount Due</td>
<td>Estimated amount due as the difference between &quot;total charges&quot; and any deductions, such as other coverage.</td>
<td>C C</td>
<td>2300B</td>
<td></td>
<td>AMT02</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMT01+0</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Pay to provider National Provider identifier (NPI).</td>
<td>R R</td>
<td>2300B</td>
<td></td>
<td>AMT02</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMT01+0</td>
<td></td>
</tr>
<tr>
<td>57A – 57C</td>
<td>Other, PRV ID</td>
<td>Other provider IDs (e.g., legacy number/Select Health facility ID or taxonomy). This is required for providers not submitting an NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan as listed in fields 50A, 50B, and 50C.</td>
<td>C C</td>
<td>2300B</td>
<td></td>
<td>AMT02</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMT01+0</td>
<td></td>
</tr>
</tbody>
</table>

*Required or conditional indicates that the field is required or conditional for the relevant billing type.
## UB-04 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional?</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>58a – 58c</td>
<td>Insured's Name</td>
<td>Refers to the insured/subscriber for the payer listed in field 50.</td>
<td></td>
<td>R</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If patient = subscriber</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2010BA</td>
<td>NM103, 04</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If patient not = subscriber</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2330A</td>
<td>NM103, 04</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>59a – 59c</td>
<td>P. REL</td>
<td>Patient's relationship to insured.</td>
<td></td>
<td>R</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60a – 60c</td>
<td>Insured's Unique ID</td>
<td>Group health member ID number.</td>
<td></td>
<td>R</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group health — required if field 58 is populated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Secondary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Tertiary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61a – 61c</td>
<td>Group Name</td>
<td>Group health — required if field 58 is populated</td>
<td></td>
<td>C</td>
<td>C</td>
<td>2000B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Secondary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Tertiary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62a – 62c</td>
<td>Insured Group Number</td>
<td>Other insurance group number.</td>
<td></td>
<td>C</td>
<td>C</td>
<td>2000B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Secondary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Tertiary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Code</td>
<td>Prior authorization number.</td>
<td></td>
<td>R</td>
<td>R</td>
<td>2300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enter the Select Health prior authorization number if the services rendered required prior authorization.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>DCN</td>
<td>Document control number.</td>
<td></td>
<td>C</td>
<td>C</td>
<td>2320</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assigned by the payer to the original claim.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Employer Name</td>
<td>Name of the employer that provides health care coverage. This is required when the employer of the insured is known to potentially be involved in paying this claim.</td>
<td></td>
<td>C</td>
<td>C</td>
<td>2320</td>
</tr>
<tr>
<td>66</td>
<td>DX and Procedure Code Qualifier</td>
<td>ICD version indicator. 0 denotes ICD-10. This is not required.</td>
<td></td>
<td>C</td>
<td>C</td>
<td>2300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claims with invalid codes will be denied.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## UB-04 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional?</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>67A – 67J</td>
<td>Principal Diagnosis and Present on Admission (POA) indicator</td>
<td>ICD code describing the principal diagnosis. Exclude diagnoses that relate to an earlier episode and have no bearing on the current hospital service.</td>
<td></td>
<td>R</td>
<td>R</td>
<td>2300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The DX chiefly responsible for the use of hospital services, all conditions that coexist at the time of service, or conditions that develop after the service that affect the length of stay.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>68</td>
<td>Unlabeled field</td>
<td>POA</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>69</td>
<td>Admit DX</td>
<td>Admitting diagnosis code. This is required for inpatient and outpatient.</td>
<td></td>
<td>R</td>
<td>R</td>
<td>2300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The code stated by the physician describing the patient's DX at the time of admission.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70a – 70c</td>
<td>Patient Reason DX</td>
<td>Patient's reason for visit. Code describing the patient's reason for the visit at the time of registration.</td>
<td></td>
<td>R</td>
<td>R</td>
<td>2300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The PPS code assigned to the claim to identify the diagnosis-related group (DRG) based on the grouper software called for under contract with the primary payer. Required when the health plan and provider contract requires this information. Up to four digits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>PPS Code</td>
<td>Prospective payment system (PPS) code.</td>
<td></td>
<td>C</td>
<td>C</td>
<td>2300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The PPS code assigned to the claim to identify the diagnosis-related group (DRG) based on the grouper software called for under contract with the primary payer. Required when the health plan and provider contract requires this information. Up to four digits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>72a – 72c</td>
<td>External Cause of Injury (ECI) Code</td>
<td>The ICD code pertaining to external cause of injury, poisoning, or adverse effect.</td>
<td></td>
<td>C</td>
<td>C</td>
<td>2300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The external cause codes should not be billed as the primary or admitting DX.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>Unlabeled field</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>74</td>
<td>Principal Procedure Principal Procedure Date</td>
<td>The appropriate ICD code that identifies the principal procedure performed at the claim level.</td>
<td></td>
<td>C</td>
<td>C</td>
<td>2300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgical procedure code is required if the operating room was used — inpatient facility.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT, HCPCS, or ICD code is required when a surgical procedure is performed in the ASC or outpatient facility.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>Unlabeled field</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### UB-04 Claim Form required fields

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Instructions and comments</th>
<th>Required or conditional*</th>
<th>Loop ID</th>
<th>Segment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>76</td>
<td>Attending Physician Name and Identifiers</td>
<td>Required if a surgical code is listed.</td>
<td>C C</td>
<td>2310B</td>
<td>2310B</td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>Operating Physician Name and Identifiers</td>
<td>Required if a surgical code is listed.</td>
<td>C C</td>
<td>2310C</td>
<td>2310C</td>
<td></td>
</tr>
<tr>
<td>78 – 79</td>
<td>Other Provider</td>
<td>Other operating physician's name.</td>
<td>R R</td>
<td>2310D</td>
<td>2310D</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>Claim note.</td>
<td>C C</td>
<td>2310E</td>
<td>2310E</td>
<td></td>
</tr>
</tbody>
</table>

**Paper UB-04 NDCs**

- The NDC must be entered in Form Locator 43 in the Revenue Description field.
- Report the N4 qualifier in the first two positions, left-justified.
  - Do not enter spaces.
  - Enter the 11-character NDC number in the 5-4-3 format (no hyphens). Do not submit any other information on the line with the NDC. Drug name and strength should not be included on the line with the NDC.
  - Do not use 99999999999 for a compound medication. Bill each drug as a separate line item with its appropriate NDC.
- Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier.

<table>
<thead>
<tr>
<th>NDC quantity unit qualifier</th>
<th>Unit of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>F2</td>
<td>International unit</td>
</tr>
<tr>
<td>GR</td>
<td>Gram</td>
</tr>
<tr>
<td>ML</td>
<td>Milliliter</td>
</tr>
<tr>
<td>UN</td>
<td>Unit</td>
</tr>
</tbody>
</table>

- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to three digits (to the right of the decimal).
- Any unused spaces for the quantity are left blank.

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

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

**EDI UB-04 NDCs**

EDI claims with NDC information must be reported in the LIN segment of loop ID-2410 as required by government regulation. This segment is used to specify billing and reporting for drugs provided that may be part of the service(s) described in SV2. Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line. Claims requiring multiple NDCs sent at claim line level should be submitted using a CMS 1500 or UB-04 paper claim.
When submitting the NDC in the LIN segment, the CTP segment is required with 5010 HIPAA. This segment is to be submitted with the Unit of Measure and the Quantity.

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

- Federal tax ID on UB-04: Federal tax ID on UB-04 (box 5) will come from loop 2010AA, REF02.
- Condition codes: Condition codes (boxes 18 through 29) will come from 2300 CRC01 – CRC07.
- Patient reason DX: Patient reason DX (box 70) qualifier will be PR qualifier from 2300, HI0.

Submission of present on admission (POA) indicators for primary and secondary diagnoses

POA reporting background

On February 8, 2006, the President signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the identification of conditions that:

- Are high cost, or high volume, or both.
- Result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis.
- Could reasonably have been prevented through the application of evidence-based guidelines. Section 5001(c) provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions.

CMS required hospitals to report POA information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007.

For discharges occurring on or after October 1, 2008, hospitals were not to receive additional payment for cases in which one of the conditions was not present on admission. The case would be paid as though the secondary diagnosis were not present.

General POA requirements

- POA indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.
- POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency room, observation, and outpatient surgery, are considered POA.

- A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes. CMS does not require a POA indicator for an external cause of injury code unless it is being reported as an “other diagnosis.”

- For dates of service on or after October 1, 2015, electronic claims submissions should follow the guidelines published in conjunction with the UB-04 Data Specifications Manual and the ICD-10-CM official guidelines for coding and reporting. The POA indicator should also be reported for external causes of morbidity. External causes of morbidity categories for which the POA indicator is not applicable are exempt from editing.
  - Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.
  - If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, the POA indicator would not be reported.

POA coding

Use the UB-04 Data Specifications Manual and the ICD Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each principal diagnosis and other ICD diagnosis codes reported on the UB-04 and ASC X12N 837 Institutional (837I).

Hospitals reporting with the 5010 format will no longer report a POA indicator of 1 for POA exempt codes. The POA field will instead be left blank for codes exempt from POA reporting.

Reporting POA on the UB-04 Claim Form

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

We include a sample UB-04 populated with primary and secondary diagnosis codes and POA indicators.

---

### POA indicators

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason for code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes. The condition was present at the time of inpatient admission.</td>
</tr>
<tr>
<td>N</td>
<td>No. The condition was not present at the time of inpatient admission.</td>
</tr>
<tr>
<td>U</td>
<td>Unknown. The documentation is insufficient to determine if the condition was present at the time of inpatient admission.</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined. The provider is unable to clinically determine whether the condition was present at the time of inpatient admission.</td>
</tr>
<tr>
<td>1</td>
<td>Exempt from POA reporting for paper claims.</td>
</tr>
<tr>
<td>Blank</td>
<td>Exempt from POA reporting for electronic claims.</td>
</tr>
</tbody>
</table>

---

**POA indicator definitions**

- **POA indicator definitions**
  - A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes. CMS does not require a POA indicator for an external cause of injury code unless it is being reported as an “other diagnosis.”
  - For dates of service on or after October 1, 2015, electronic claims submissions should follow the guidelines published in conjunction with the UB-04 Data Specifications Manual and the ICD-10-CM official guidelines for coding and reporting. The POA indicator should also be reported for external causes of morbidity. External causes of morbidity categories for which the POA indicator is not applicable are exempt from editing.
  - Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.
  - If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, the POA indicator would not be reported.

**POA coding**

Use the UB-04 Data Specifications Manual and the ICD Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each principal diagnosis and other ICD diagnosis codes reported on the UB-04 and ASC X12N 837 Institutional (837I).

Hospitals reporting with the 5010 format will no longer report a POA indicator of 1 for POA exempt codes. The POA field will instead be left blank for codes exempt from POA reporting.

**Reporting POA on the UB-04 Claim Form**

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

We include a sample UB-04 populated with primary and secondary diagnosis codes and POA indicators.
Reporting POA in electronic 837I format

Submit POA data via the NTE segment on all 837I claims (005010X223A2).

Although this segment can repeat, the plan requires submission of POA data on a single K3 segment. No additional K3 segments with the letters POA will be validated.

- **K301** must contain POA as the first three characters or the POA data will not be picked up (K3*POA~).
- **NTE** segment must only contain details pertaining to the principal and other diagnosis found in the HI segment with qualifiers BK for the principal and BF for the other diagnosis prior to the ending Z (or X).
- The POA indicator for the BN — External Cause of Injury on the NTE segment with POA is entered following the ending Z (or X). This is also required by Change Healthcare (formerly Emdeon) for Medicare claims.
- No POA indicator is to be sent for the BJ/ZZ — Admitting Diagnosis Data. Only letters identified on the Medicare Bulletin should follow the letters POA in the NTE segment. Y, N, U, and W are valid, with the ending characters of X or Z and E code indicator. This table outlines the payment implications for each of the different POA indicators.

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason for code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at the time of inpatient admission. CMS will pay the complicating condition or major complicating condition (CC/MCC) DRG for those selected hospital-acquired conditions (HACs) coded as “Y” for the POA indicator.</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs coded as “N” for the POA indicator.</td>
</tr>
<tr>
<td>U</td>
<td>Documentation insufficient to determine if the condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs coded as “U” for the POA indicator.</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs coded as “W” for the POA indicator.</td>
</tr>
<tr>
<td>1</td>
<td>Unreported/not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks were undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs coded as “1” for the POA indicator. The “1” POA indicator should not be applied to any codes on the HAC list.</td>
</tr>
</tbody>
</table>

Key points

- With the implementation of 5010 Inpatient Prospective Payment System (IPPS) hospitals will no longer report the POA indicator of 1.
- ICD-CM diagnosis codes that are exempt from the POA reporting requirement should be left blank instead of populating them with a 1.
- In addition, the K3 segment, which was required for reporting POA in the 4010A1 version of the 837I, is no longer used to report POA.
- For 5010 the POA indicators will instead follow the diagnosis code in the appropriate 2300 HI segment.

All patient-refined diagnosis-related groups (APR-DRGs)

Effective for dates of service on or after January 1, 2012, Select Health moved to the All Patient Refined Diagnosis Related Groups (APR-DRGs) method of paying for hospital inpatient services.

The goals of the APR-DRGs payment are to employ a methodology that is sustainable and more appropriate to Medicaid using a modern DRG algorithm, which enables reduced payment for hospital-acquired conditions and simplifies the current payment method.

APR-DRGs version 32 replaced the 3M grouper version 28 with the implementation of ICD-10.

APR-DRGs is a classification system that classifies patients according to:

- Reason for admission.
- Severity of illness (SOI).

APR-DRGs grouping process:

- SOI is used for payment calculation.
- Depends on patient diagnosis and procedures.
- Severity levels define the degree of illness a patient is experiencing.

Payment is adjusted to appropriately reimburse hospitals at a higher level for treating sicker patients.

This payment method will apply to general acute care hospitals (including distinct-part units of general hospitals both inside and outside South Carolina).

Payment methods for inpatient services provided by free-standing long-term psychiatric facilities and residential treatment facilities are unaffected.
Birth weight

With the implementation of the APR-DRGs payment methodology, Select Health must ensure we are reporting the appropriate encounter data for abnormal birth weights; therefore, we are requesting providers’ bill as follows:

- Please use ICD-10 CM code ranges P07.0 – P07.18 and P05.00 – P05.09 as appropriate.
- Birth weight can be reported through use of value code 54 followed by the actual birth weight in grams, but the appropriate diagnosis (P code range above) must also be included.
- Birth weight must be numeric.
- Birth weight must be a whole number without decimal points.
- Birth weight cannot be greater than four numeric characters (9999).

Birth weight billing examples

**UB-04 paper claim**

If reporting abnormal birth weight through the use of the applicable ICD-10 code, populate field 67.

If reporting abnormal birth weight through the use of value codes, populate fields 39, 40, 41a – 41d, value codes, and amounts. Use value code 54 for newborn birth weight in grams.

**Electronic billing**

If billing electronically in addition to reporting the diagnosis code, please report abnormal birth weight in loop 2300, segment HI, with the qualifier BE, value code 54 in HI01-2, and the newborn’s weight in grams in the monetary amount field, HI01-5.

Common causes of claim processing delays, rejections, and denials

**Authorizations or referral number invalid or missing** — A valid authorization number must be included on the claim form for all services requiring prior authorization.

**Attending physician ID missing or invalid** — Inpatient claims must include the name of the physician who has primary responsibility for the patient’s care or treatment and the medical license number in field 76 on the UB-04 claim form. Medical license number formats are: two alpha, six numeric, one alpha (AANNNNNA) or two alpha, and six numeric characters (AANNNNNN).

**Billed charges missing or incomplete** — A billed charge amount must be included for each service, procedure, and supply on the claim form.

**Coordination of benefits (COB)** — Pertains to the other payer found in 2330B. For the COB, the plan is considered the payer of last resort.

**Diagnosis code missing fourth or fifth digit** — Precise coding sequences must be used to accurately complete processing. Review the ICD-CM manual for the fourth- and fifth-digit extensions. The fourth or fifth symbol in the manual determines when additional digits are required.

**Diagnosis, procedure or modifier codes invalid or missing coding** — This coding from the most current coding manuals (ICD-CM, CPT or HCPCS) or appropriate unique coding is required to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

**DRG codes missing or invalid** — Hospitals contracted for payment based on DRG codes should include this information on the claim form.

**EOB from primary insurer missing or incomplete** — A copy of the EOB from all third-party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations, and messages.

**EPSDT information missing or incomplete** — EPSDT information should be billed in accordance with the South Carolina Medicaid Physician Provider Manual. Immunization administration, topical fluoride varnish, laboratory tests, blood level assessments, age-limited screenings, and elective tests are covered separately using the appropriate CPT code and billed according to the periodicity schedule. EPSDT services may be submitted electronically or on paper.

For complete EPSDT billing guidelines, refer to Early, Periodic, Screening, and Diagnostic Testing (EPSDT) Claims in the Appendix of this manual.

**External cause of injury codes** — External causes of injury, E diagnosis codes, should not be billed as primary and/or admitting diagnoses.

**Future claim dates** — Claims submitted for medical supplies or services with future claim dates will be denied. For example, a claim submitted on Oct. 1 for bandages that are delivered for October 1 through October 31, will deny for all days except October 1.

**Handwritten claims** — See illegible claim information.

**Highlighted claim fields** — See illegible claim information.

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

Member name missing — The name of the member must be present on the claim form and must match the information on file with the plan.

Member Medicaid or health plan ID number missing or invalid — The Medicaid or health plan’s assigned member ID must be included on the claim form or electronic claim submitted for payment.

Member date of birth does not match member ID submitted — Claims submitted with the incorrect date of birth will be rejected on the front end. The date of birth must be present on the claim form and must match the information on file with the plan.

Newborn claim information missing/invalid or multiple births — Newborns must be billed separately from the mother. If the baby has not been named, insert “Girl” or “Boy” in front of the mother’s last name as the baby’s first name. Verify that the appropriate last name is recorded for the mother and baby. The claim for the baby must include the baby’s date of birth and Medicaid number. Please do not use the mother’s DOB or Medicaid number. On claims for twins or other multiple births, indicate the birth order in the patient name field. For example: Baby Girl Smith A, Baby Girl Smith B.

Payer or other insurer information missing or incomplete — Include the name, address and policy number for all insurers covering the plan member.

Place of service code missing or invalid — A valid and appropriate two-digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes.

Provider name missing — The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the plan. The individual service provider name and NPI number must be included on all claims, excluding ambulance service providers, DME, and home health agencies and laboratories. Using only the group or billing entity name and number will result in rejections, denials, or inaccurate payments.

Provider NPI number missing or invalid — The individual and group NPI numbers for the service provider must be included on the claim form. When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI numbers results in inaccurate payments or denials.

Revenue codes missing or invalid — Facility claims must include a valid three- or four-digit numeric revenue code. Refer to UB-04 coding manuals for a complete list of revenue codes.

Signature missing — The signature of the provider of service or “signature on file” or “SOF” should be present on the claim form and must match the service provider name and TIN on file with the plan. This does not apply to provider types: ambulance, DME, home health, lab, hospital or DHEC. Claims without the provider signature or “signature on file” in box 31 will be rejected. The provider is responsible for resubmitting these claims within one year from the date of service.

Spanning dates of service do not match the listed days or units — Span-dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days or units field.

Tax identification number (TIN) missing or invalid — The tax ID number must be present and must match the service provider name and payment entity (vendor) on file with the plan. Claims without a TIN will be rejected. The provider is responsible for resubmitting these claims within one year from the date of service.

Third-party liability (TPL) information missing or incomplete — Any information indicating a work-related illness or injury, no fault or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer’s EOB or applicable documentation must be forwarded along with the claim form.

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

Taxonomy — The provider’s taxonomy number is required on all claims.

Important billing reminders

• Include all primary and secondary diagnosis codes on the claim.
• Missing or invalid data elements or incomplete claim forms will cause claim-processing delays, inaccurate payments, rejections, or denials.
• Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
• All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
• State-level HCPCS coding takes precedence over national-level codes unless otherwise specified in individual provider contracts.
• The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit the claim with the appropriate coding, which matches the total charges on the EOB.
• Secondary claims can also be submitted electronically. Refer to the section entitled Submitting Secondary Claims Electronically.
The provider is responsible for resubmitting these claims within 365 days.

Claims without a tax identification number (TIN) will be rejected.

The claim for baby must include the baby’s date of birth instead of the mother’s date of birth, and the appropriate DX code.

The claim must also include the baby’s birth weight (value code 54).

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

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

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

When submitting claims electronically, the provider NPI number must be entered at the claim level instead of the claim line level. The claim must also include the baby’s birth weight (value code 54).

The claim for baby must include the baby’s date of birth instead of the mother’s date of birth, and the appropriate DX code.

CMS 1500 (02/12) and UB-04 paper claims rejection criteria

<table>
<thead>
<tr>
<th>Field number</th>
<th>CMS 1500 (02/12) field or data elements</th>
<th>Rejection statements (rejection criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Patient's Name</td>
<td>“Member name is missing or illegible.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If first and/or last name are missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date</td>
<td>“Member’s date of birth (DOB) is missing.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If the claim is missing month and/or day and/or year, it will be rejected.)</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Sex</td>
<td>“Member’s sex is required.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If no box is checked, the claim will be rejected.)</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td>“Insured’s name missing or illegible.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If first and/or last name is missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address (number, street, city, state, ZIP code) and Phone</td>
<td>“Patient address is missing.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If street number, street name, city, state, or ZIP code are missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td>“Patient relationship to insured is required.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If none of the four boxes are selected, the claim will be rejected.)</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address (number, street, city, state, ZIP code) and Phone</td>
<td>“Insured’s address is missing.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If street number, street name, city, state, or ZIP code are missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>21</td>
<td>Information Related to Diagnosis/ Nature of Illness/Injury</td>
<td>“Diagnosis code is missing or illegible.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(The claim will be rejected.)</td>
</tr>
<tr>
<td>22</td>
<td>Resubmission code/Original Reference Number</td>
<td>For corrected claims: “Resubmission code or original claim number is missing.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If the resubmission code or original claim number is missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>24</td>
<td>Supplemental Information</td>
<td>“National Drug Code (NDC) data is missing/incomplete/invalid.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(The claim will be rejected if NDC data is missing or incomplete, or has an invalid unit or basis of measurement.)</td>
</tr>
<tr>
<td>24A</td>
<td>Date of Service</td>
<td>“Date of service (DOS) is missing or illegible.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(The claim will be rejected if both the “From” and “To” DOS are missing or illegible. If only the “From” or “To” DOS is billed, the other DOS will be populated with the DOS that is present.)</td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td>“Place of service is missing or illegible.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Claim will be rejected.)</td>
</tr>
<tr>
<td>24D</td>
<td>Procedure, Services, or Supplies</td>
<td>“Procedure code is missing or illegible.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Claim will be rejected.)</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
<td>“Diagnosis (DX) pointer is required on line ___.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(For each service line with a “From” DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>24F</td>
<td>Line Item Charge Amount</td>
<td>“Line item charge amount is missing on line ___.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If a value greater than or equal to zero is not present on each valid service line, the claim will be rejected.)</td>
</tr>
<tr>
<td>24G</td>
<td>Days/Units</td>
<td>“Days/units are required on line ___.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(For each line with a “From” date of service, days and units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)</td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider Identification</td>
<td>“National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If NPI is missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>26</td>
<td>Patient Account/Control Number</td>
<td>“Patient Account/Control Number is missing or illegible.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If this is missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>27</td>
<td>Assignment Number</td>
<td>“Assignment acceptance must be indicated on the claim.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If “Yes” or “No” is not checked, the claim will be rejected.)</td>
</tr>
<tr>
<td>28</td>
<td>Total Claim Charge Amount</td>
<td>“Total charge amount is required.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If a value greater than or equal to zero is not present, the claim will be rejected.)</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician Or Supplier</td>
<td>“Provider name is missing or illegible.”</td>
</tr>
<tr>
<td></td>
<td>Including Degrees Or Credentials</td>
<td>(If the provider name, including degrees or credentials, and date are missing or illegible, the claim will be rejected. “Signature on file” or “SOF” are acceptable.)</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Information and Phone</td>
<td>“Billing provider name and/or address is missing or incomplete.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If the provider’s name, street number, street name, city, state, or ZIP code are missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Information and Phone</td>
<td>“Field 33 of the CMS1500 claim form requires the provider’s physical service address.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If a P.O. box is present, the claim will be rejected.)</td>
</tr>
</tbody>
</table>
### UB-04 paper claims rejection criteria

<table>
<thead>
<tr>
<th>Field number</th>
<th>UB-04 field or data elements</th>
<th>Rejection statements (rejection criteria)</th>
<th>Effective April 1, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Billing Provider Name, Address, and Phone Number</td>
<td>&quot;Billing provider name and/or address missing or incomplete.&quot; (If the provider’s name, street number, street name, city, state, or nine-digit ZIP code are missing, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>1</td>
<td>Billing Provider Name, Address, and Phone Number</td>
<td>&quot;Field 1 of the UB-04 claim form requires the provider’s physical service address.&quot; (If a P.O. box is present, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Account/Control Number</td>
<td>&quot;Patient account/control number is missing or illegible.&quot; (If the number is missing or illegible, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>8b</td>
<td>Patient Name</td>
<td>&quot;Member name is missing or illegible.&quot; (If first and/or last name are missing or illegible, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>9a-e</td>
<td>Patient Address</td>
<td>&quot;Patient address is missing.&quot; (If the street number, street name, city, state, or ZIP code are missing, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>10</td>
<td>Patient Birth Date</td>
<td>&quot;Member DOB is missing.&quot; (If missing, month, day, or year, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>11</td>
<td>Patient Sex</td>
<td>&quot;Member’s sex is required.&quot; (If this is left blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>&quot;Admission date is missing or illegible.&quot; (Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim. If it is OP, do not reject the claim. If it is IP and a valid date is not billed, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour</td>
<td>&quot;Admission hour is required.&quot; (Use the bill type table to identify if it is an IP or OP claim. If it is OP, do not reject the claim. If it is IP and the bill type is anything except 21X, a numeric value is not billed on the claim, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>14</td>
<td>Admission Type</td>
<td>&quot;Admission type is required.&quot; (If a numeric value is not present, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>15</td>
<td>Source of Referral for Admission or Visit</td>
<td>&quot;Source of referral for admission or visit is missing.&quot; (If the claim has any bill type except 14X and the field is blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour</td>
<td>&quot;Discharge hour is required.&quot; (Use the bill type table to determine if it is an IP or OP bill type. If IP, and the frequency code is either 1 or 4, and this field is blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>17</td>
<td>Patient Discharge Status</td>
<td>&quot;Patient discharge status is required.&quot; (If this is left blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>&quot;Revenue code is missing or illegible.&quot; (If the revenue code is missing or illegible, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td>&quot;DOS is missing or illegible.&quot; (The claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>45</td>
<td>Creation Date</td>
<td>&quot;Creation date is missing or illegible.&quot; (If the creation date is missing or illegible, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>46</td>
<td>Service Days/Units</td>
<td>&quot;Days/units are required on line ___&quot; (Lines 1 – 22). (For each line with a &quot;From&quot; DOS, days and units are required if a numeric value is not present on each valid service line, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>47</td>
<td>Line Item Charges</td>
<td>&quot;Line item charge amount is missing on line ___.&quot; (Lines 1 – 22). (If a value greater than or equal to zero is not present, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>&quot;Total charge amount is missing.&quot; (If a value greater than or equal to zero is not present, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>50</td>
<td>Payer</td>
<td>&quot;Payer name is required.&quot; (If this is blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>52</td>
<td>Release of Information</td>
<td>&quot;Release of information certification indicator is required.&quot; (If this is blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>53</td>
<td>Assignment of Benefits</td>
<td>&quot;Assignment of benefits certification indicator is required.&quot; (If this is blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
</tbody>
</table>

### UB-04 paper claims rejection criteria

<table>
<thead>
<tr>
<th>Field number</th>
<th>UB-04 field or data elements</th>
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<th>Effective April 1, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>Insured’s Name</td>
<td>&quot;Member name is missing or illegible.&quot; (If the first or last name is missing or illegible, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>59</td>
<td>Patient’s Relationship</td>
<td>&quot;Patient’s relationship to insured is required.&quot; (If this is blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>67A – 67Q</td>
<td>Other Diagnosis Codes and Present on Admission Indicator</td>
<td>&quot;Diagnosis codes are missing or illegible.&quot; (If diagnosis codes are missing or illegible, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis Code</td>
<td>&quot;Admitting diagnosis code is missing or illegible.&quot; (If it is an IP claim and the field is blank or illegible, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>70</td>
<td>Patient’s Reason for Visit</td>
<td>&quot;Patient’s reason for visit is missing.&quot; (If the claim is OP and the field is blank, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>74</td>
<td>Other/Procedure Date</td>
<td>&quot;Based on the date the claim was received, procedure date is a future date.&quot; (Use the bill type table to identify if it is an IP or an OP claim. If it is OP, do not reject the claim. If it is IP and a future date is billed, reject the claim.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Identifiers: Name and NPI</td>
<td>&quot;Attending physician name and/or number is missing.&quot; (If the attending physician name or NPI number is missing, the claim will be rejected.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Qualifier</td>
<td>&quot;Attending provider qualifier is missing/invalid.&quot; (The claim will be rejected if the &quot;Other provider ID&quot; is present and either of these is true: • The ‘Qualifier’ box is blank. • A qualifier other than OB/GD/G2 is present.)</td>
<td>Effective April 1, 2015</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Other ID Number</td>
<td>&quot;Attending Provider NPI is missing.&quot; (The claim will be rejected if a qualifier is present and the NPI box is blank.)</td>
<td>Effective April 1, 2015</td>
</tr>
</tbody>
</table>

### Electronic data interchange (EDI) for medical and hospital claims

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

The benefits of billing electronically include:

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

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

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

To verify satisfactory receipt and acceptance of submitted records, please review both the Change Healthcare Acceptance report and the R059 Plan Acceptance Report (Claim Status Report).

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

Submitting secondary claims electronically

The required coordination of benefits (COB) data elements for submitting EDI claims to Select Health may be gathered from the previous payer’s adjudication, in both paper and electronic (835) remittance advice formats.

To submit provider-to-payer COB claims via EDI, you must have a system, data entry process or clearinghouse able to:

• Create or forward claims directly to EDI in the HIPAA 837 format or a format with the same information.
• Process payment information by one of the following:
  – Receiving a HIPAA-standard electronic remittance advice (ERA) format from the previous payer.
  – Coding a paper remittance into the electronic claim.

Select Health’s COB data requirements align with HIPAA guidelines. The 837 Implementation Guide may be found online at https://msp.scdhhs.gov/managedcare/ — Encounter Companion Guides.

The following sections describe the procedures for electronic submission for hospital and medical claims, including claim and report process flows, unique electronic billing requirements, and various electronic submission exclusions.

If you are a provider who already has electronic filing capabilities, you should contact your vendor and confirm the vendor will transmit claims to Change Healthcare Select Health’s claims clearinghouse.

Providers should confirm the accurate location of Select Health provider ID number with the vendor, if submitting this information on the claim. If viewing a CMS 1500, the individual provider ID number should be submitted in the box 24j shaded area. If viewing a UB-04, the ID number should be submitted in box 51.

Hospitals and facilities — Please use the facility ID number assigned by Select Health.

Submit with payer ID 23285.

The provider should check the claim status report after each submission for any rejections. If rejections are noted, correct and resubmit the claim.

Questions regarding electronically submitted claims should be directed to the Provider Contact Center at 1-800-575-0418. Here you may obtain information about submitting claims electronically to Select Health or information regarding claims that have already been submitted electronically to Select Health.

Hardware and software requirements

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

Contracting with Change Healthcare and other electronic vendors

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

Change Healthcare is the largest clearinghouse for EDI health care transactions in the world. It has the capability to accept electronic data from numerous providers in several standardized EDI formats. Change Healthcare then forwards accepted information to carriers in an agreed-on format.

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

When you are ready to proceed:

• Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and, especially, the rejection notification reports.
• Inform your EDI software vendor and/or Change Healthcare that you wish to initiate electronic submissions to the plan.
• Be prepared to inform the vendor of the plan’s electronic payer identification number. The payer ID for Select Health is 23285.

You can contact Change Healthcare Sales at 1-800-845-6592.
Contacting the EDI Technical Support Group

Providers with questions about submitting claims electronically may contact the EDI Technical Support Group for information and assistance in beginning electronic submissions.

Contact EDI Technical Support at 1-888-394-3100 or edi.sh@kmhp.com.

Specific data record requirements

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

Direct claim entry web tool

For small to medium size health care practices that have a small volume of claims to submit and/or may not use a practice management system, Select Health offers a direct claim entry web tool through the Change Healthcare clearinghouse. This tool enables your practice to manually enter CMS-1500 claims data that will be electronically submitted to Select Health. Direct claim entry is an alternative to paper submission for professional claims and is available through our provider portal, NaviNet, or by visiting Change Healthcare directly at office.emdeon.com/vendorfiles/amerihealth.html.

Since there is no specialized software, there is no cost or per transaction fees to the provider when using the direct entry claim portal.

For assistance with using the portal, Change Healthcare provides a wealth of educational materials, including online training, reference guides, and customized training. Simply select the online help links within the product. If additional assistance is needed, contact Change Healthcare customer service at 1-877-469-3263, option 2.

Electronic claim flow description

To send claims electronically to the plan, all EDI claims must first be forwarded to Change Healthcare. This can be completed via a direct submission or through another EDI clearinghouse or vendor.

Once Change Healthcare receives the transmitted claims, they are validated against Change Healthcare’s proprietary specifications, Health Insurance Portability and Accountability Act (HIPAA) compliance, and plan-specific requirements. Claims not meeting the requirements are immediately rejected and returned to the sender via a Change Healthcare error report. The name of this report can vary based on the provider’s contract with an intermediate EDI vendor or Change Healthcare.

Accepted claims are passed to the plan, and Change Healthcare returns an acceptance report to the sender immediately.

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

Invalid electronic claim record rejections and denials

All claim records sent to the plan must first pass Change Healthcare proprietary edits and HIPAA and plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 365 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Acceptance (Claim Status) Reports received from Change Healthcare or your EDI software vendor to identify and resubmit these claims accurately.

Claim status can be checked through the plan’s Provider Claims Service Unit’s IVR system by calling 1-800-845-6592. If you need help resolving submission issues identified on the R059 Plan Claim Status report, contact the EDI Technical Support Hotline at 1-888-394-3100 or by email at edi.sh@kmhp.com.

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

Timely filing note: Your claims must be received by the EDI vendor by 9 p.m. ET to be transmitted to the plan the next business day. When you receive the Rejection report from Change Healthcare or your EDI vendor, the plan does not receive a record of the rejected claim.
Change Healthcare will produce an Acceptance Report and a R059 Plan Acceptance (Claim Status) Report for its trading partner, whether it is the EDI vendor or provider. Providers using Change Healthcare or other clearinghouses and vendors are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments.

An Acceptance Report verifies acceptance of each claim at Change Healthcare.

A R059 Plan Acceptance (Claim Status) Report is a list of claims that passed Change Healthcare’s validation edits, but, when submitted to the plan, encountered provider or member eligibility edits.

Plan-specific electronic edit requirements

The plan currently has two specific edits for professional (P) and institutional (I) claims sent electronically:

- **837P — 005010X222A1**: Provider ID payer edit states the ID must be fewer than 13 alphanumeric digits.
- **837I — 005010X223A2**: Provider ID payer edit states the ID must be fewer than 13 alphanumeric digits.

The plan’s provider ID is to be sent as follows:

- **837P — Loop 2310B, REF01* G2 qualifier, REF02**: Rendering provider network ID.
- **837I — Loop 2310A, REF01* G2 qualifier, REF02**: Rendering provider network ID.

Requests for adjustments may be submitted by phone to the Provider Contact Center at 1-800-575-0418.

Administrative or medical appeals must be submitted in writing to:

Select Health of South Carolina
Attn: Member Appeals
P.O. Box 40849
Charleston, SC 29423-0849

Refer to the provider manual located in the provider section online at www.selecthealthofsc.com for complete instructions on submitting administrative or medical appeals.

Corrected professional claims may be sent in on paper via CMS 1500. Please do not stamp each claim submitted with “corrected” or “resubmission.” Submit the correct resubmission code (7 or 8) in box 22 and include the original claim number. Send all corrected or resubmitted claims to:

Select Health of South Carolina
Claims Processing Department
P.O. Box 7120
London, KY 40742

Alternatively, you can resubmit corrected professional claims electronically. Refer to the section called Corrected Claims via EDI in this manual.

Corrected institutional claims can be resubmitted electronically. Be sure to use the appropriate bill type to indicate it is a corrected claim. The last character should be a 7 for an adjustment or an 8 for a void.

Exclusions

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

- **Excluded claim categories**: at this time, these claim records must be submitted on paper.
- **Excluded provider categories**: claims issued from or on behalf of the following providers must be submitted on paper.

These exclusions apply to inpatient and outpatient claim types.

Excluded claim categories

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

Excluded provider categories

- Excluded provider categories.
- Providers not transmitting through Change Healthcare or providers sending to vendors that are not transmitting through Change Healthcare.
- Non-emergent transportation.
- Pharmacy (through Change Healthcare).
Common rejections

Invalid electronic claim records — common rejections from Change Healthcare

• Claims with missing or invalid batch-level records.
• Claim records with missing or invalid required fields.
• Claim records with invalid (e.g., unlisted or discontinued) codes (e.g., CPT-4, HCPCS, or ICD).
• Claims without provider numbers.
• Claims without member numbers.
• Claims in which the date of birth submitted does not match the member ID.
• Claims submitted with a P.O. box in the billing provider address field (box 33).

Invalid electronic claim records — common rejections from the plan (EDI edits within the claim system)

• Claims received with invalid provider numbers.
• Claims received with invalid member numbers.
• Claims received with invalid member date of birth.

National provider identifier (NPI) processing

The plan’s provider number is determined from the NPI number using the following criteria:

• Plan ID, tax ID, and NPI number.
• If no single match is found, the service location’s full nine-character ZIP code + four digits is used.
• If no service location is included, the billing address’ full nine-character ZIP code + four digits will be used.
• If no single match is found, the required taxonomy is used.
• If no single match is found, the claim is sent to the invalid provider queue (IPQ) for processing.
• If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim. The legacy plan ID is used as the primary ID on the claim.
• If you have submitted a claim and you have not received a rejection report, but you are unable to locate your claim via NaviNet, your claim might be in review by the plan. Please check with Provider Services and update your NPI data as needed. Your claim will only be processed effectively if the service location of the claim matches the claim’s NPI information.

835 Electronic remittance advice

Select Health has partnered with Change Healthcare and HDX as clearinghouses for the 835 electronic remittance advice transactions. Change Healthcare and HDX are leaders in processing transactions for vendors, providers, and health plans in the HIPAA compliant standardized formats. Providers may choose either clearinghouse from which to receive their 835 electronic remittance advice: The provider’s current EDI vendor should be contacted for additional information prior to contacting HDX or Change Healthcare.

Payer ERA enrollment forms and payer registration forms are located at changehealthcare.com.

Providers should be prepared to supply the following information during the set-up phase:

• EDI/vendor and submitter ID.
• Group/facility name.
• Contact name, phone number, and email address.
• Address.
• Tax ID.
• Payee ID.

A copy of the 835 Companion Guide can be found under Provider section of Select Health’s website under HIPAA Information. Additional assistance may be found by contacting Provider Contact Center at 1-800-575-0418.
Electronic billing inquiries

<table>
<thead>
<tr>
<th>Inquiry topic</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmitting claims electronically</td>
<td>Change Healthcare Help Desk at 1-800-845-6592</td>
</tr>
<tr>
<td>General EDI questions</td>
<td>EDI Technical Support Hotline at 1-888-394-3100 or by email at <a href="mailto:edi.sh@kmhp.com">edi.sh@kmhp.com</a></td>
</tr>
<tr>
<td>Specific claims transmissions or acceptance and R059 claim status reports</td>
<td>Your EDI Software Vendor or the Change Healthcare Help Desk at 1-800-845-6592</td>
</tr>
<tr>
<td>Claims reported on the remittance advice</td>
<td>Provider Contact Center at 1-800-575-0418</td>
</tr>
<tr>
<td>Provider ID or NPI number needed</td>
<td>Provider Contact Center at 1-800-575-0418</td>
</tr>
<tr>
<td>Update provider, payee, NPI, UPIN, tax ID number, or payment address information or changing or verifying provider information</td>
<td>Select Health of South Carolina Provider Network Operations P.O. Box 40849 Charleston, SC 29423 Fax: 1-855-316-0093 Phone: 1-800-741-6605</td>
</tr>
<tr>
<td>835 Remittance advice</td>
<td>Your EDI vendor</td>
</tr>
<tr>
<td>Check the status of your claims</td>
<td>NaviNet at <a href="http://www.navinet.net">www.navinet.net</a></td>
</tr>
<tr>
<td>Sign up for NaviNet</td>
<td><a href="http://www.navinet.net">www.navinet.net</a> or NaviNet Customer Service at 1-888-482-8057</td>
</tr>
</tbody>
</table>

Tips for accurate diagnosis coding

What is the significance of the ICD CM diagnosis code?
International Classification of Diseases Clinical Modification codes are identified as three- to five-digit codes to describe the clinical reason for a patient’s treatment and a description of the patient’s medical condition or diagnosis (rather than the service performed).

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

Have you coded for all chronic conditions for the member?
Examples of disease conditions that should always be considered and included on the submission of the claim if coexist at the time of the visit:

- Amputation status
- Bipolar disorder
- Coronary artery disease
- Cerebral vascular disease
- Chronic renal failure
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Depression
- Diabetes mellitus
- Dialysis status
- Drug or alcohol dependence
- Drug or alcohol psychosis
- HIV/AIDS
- Hypertension
- Lung and other severe cancers
- Metastatic cancer, leukemia
- Multiple sclerosis
- Paraplegia
- Quadriplegia
- Renal failure
- Schizophrenia
- Simple chronic bronchitis
- Tumors and other cancers (e.g., prostate or breast)

What are your responsibilities?
Physicians must accurately report the ICD-CM diagnosis codes to the highest level of specificity. For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:

- 250.60 Diabetes with neurological manifestations and 357.2 for diabetic polyneuropathy

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

How to minimize retrospective chart review

What is the Risk Score Adjustment Model?
The South Carolina Department of Health and Human Services (SCDHHS) uses medical encounter data from the plan to evaluate disease severity and risk of increased medical expenditures. SCDHHS employs the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, to support health-based capitation payments to the plan. Accurate payments from SCDHHS help us ensure that providers are reimbursed appropriately for services provided to our members.

The plan must obtain health status documentation from the diagnoses contained in claims data.

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

Accurate coding can be easily accomplished by keeping accurate and complete medical record documentation.
Documentation guidelines
Reported diagnoses must be supported with medical record documentation. Acceptable documentation is clear, concise, consistent, complete, and legible.

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

Physician communication tips
When used, the SOAP note format can help both the physician and record reviewer or coder identify key documentation elements.

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

EOB denial codes
This list is not all inclusive

<table>
<thead>
<tr>
<th>Denial code</th>
<th>Denial description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGO 96</td>
<td>Tier not found, category not covered</td>
</tr>
<tr>
<td>CDD 18</td>
<td>Definite duplicate claim</td>
</tr>
<tr>
<td>DUP B13</td>
<td>Duplicate denial</td>
</tr>
<tr>
<td>IO6 16</td>
<td>Claim pend: itemized bill required</td>
</tr>
<tr>
<td>IO9 47</td>
<td>Diagnosis invalid/missing/deleted/required fourth/fifth</td>
</tr>
<tr>
<td>I10 47</td>
<td>E-code cannot be used as primary diag.</td>
</tr>
<tr>
<td>I11 148</td>
<td>Claim pend: EOB from prime carrier required</td>
</tr>
<tr>
<td>I13 148</td>
<td>Claim pend: EOB/attach illegible/incomplete</td>
</tr>
<tr>
<td>I20</td>
<td>Denied claim disallow</td>
</tr>
<tr>
<td>IAA B3</td>
<td>ITS Lil allowable amount</td>
</tr>
<tr>
<td>N13 B18</td>
<td>Invalid procedure disallow</td>
</tr>
<tr>
<td>PAK 42</td>
<td>Exceeds per diem rate</td>
</tr>
<tr>
<td>P5 94</td>
<td>Exceeds service amount</td>
</tr>
<tr>
<td>P52 119</td>
<td>Exceeds the maximum number of units</td>
</tr>
<tr>
<td>PSO B1</td>
<td>Not a covered service</td>
</tr>
<tr>
<td>PSS 42</td>
<td>Exceeds the scheduled rate</td>
</tr>
<tr>
<td>Q11 63</td>
<td>Claim previously processed incorrectly</td>
</tr>
<tr>
<td>RA7 B1</td>
<td>Vaccine supplied by VFC</td>
</tr>
<tr>
<td>R00 97</td>
<td>Payment included in other billed service</td>
</tr>
<tr>
<td>R01 62</td>
<td>No pre-certification or authorization or referral</td>
</tr>
<tr>
<td>R15 97</td>
<td>Subset/incidental procedure disallow</td>
</tr>
<tr>
<td>R35 39</td>
<td>Authorization denied for this DOS</td>
</tr>
<tr>
<td>R39 B13</td>
<td>Duplicate claim previously paid at correct rate/cap</td>
</tr>
<tr>
<td>R45 B12</td>
<td>Complete medical records required</td>
</tr>
<tr>
<td>R47 23</td>
<td>Payment reflects COB, if $0, max liability met</td>
</tr>
<tr>
<td>RS1 B1</td>
<td>Service not covered</td>
</tr>
<tr>
<td>R82 16</td>
<td>Individual provider ID must be submitted</td>
</tr>
<tr>
<td>S13 26</td>
<td>All enroll events are future</td>
</tr>
<tr>
<td>S23 26</td>
<td>Date required prior to subscriber effective date</td>
</tr>
<tr>
<td>ST 27</td>
<td>Termination</td>
</tr>
<tr>
<td>TFO 29</td>
<td>Submitted after plan filing limit</td>
</tr>
<tr>
<td>TR5 96</td>
<td>Covered counter &gt;service allow ctr+rel history</td>
</tr>
<tr>
<td>UM1 62</td>
<td>Units exceed UM authorization</td>
</tr>
<tr>
<td>UM3 16</td>
<td>Pended status, zero units</td>
</tr>
<tr>
<td>Denial code</td>
<td>Denial description</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>UMO 39</td>
<td>Services disallowed by UM</td>
</tr>
<tr>
<td>X00 97</td>
<td>Payment included in other billed service</td>
</tr>
<tr>
<td>X01 62</td>
<td>No pre-certification or authorization or referral</td>
</tr>
<tr>
<td>X10 31</td>
<td>Not enrolled on date of service</td>
</tr>
<tr>
<td>X11 148</td>
<td>Claim pend: EOB from primary carrier required</td>
</tr>
<tr>
<td>X35 39</td>
<td>Authorization denied for this DOS</td>
</tr>
<tr>
<td>X39 B13</td>
<td>Duplicate claim previously paid at correct rate/cap</td>
</tr>
<tr>
<td>X45 16</td>
<td>Claim pend: complete medical records required</td>
</tr>
<tr>
<td>X50 18</td>
<td>Same procedure paid to different provider</td>
</tr>
<tr>
<td>X53 112</td>
<td>Services were not provided</td>
</tr>
<tr>
<td>X68 57</td>
<td>Invalid units submitted</td>
</tr>
<tr>
<td>X77 16</td>
<td>Incorrect provider or TIN ID number submitted</td>
</tr>
<tr>
<td>X90 16</td>
<td>UB dates of service required</td>
</tr>
<tr>
<td>X91 B7</td>
<td>Inappropriate coding for contract or agreement</td>
</tr>
<tr>
<td>X96 148</td>
<td>Claim pend: EOB/attach illegible/incomplete</td>
</tr>
<tr>
<td>X98 B7</td>
<td>Inappropriate coding for contract/ agreement</td>
</tr>
<tr>
<td>Z01 109</td>
<td>Medicaid fee-for-service</td>
</tr>
<tr>
<td>Z11 148</td>
<td>Claim pend: EOB from primary carrier required</td>
</tr>
<tr>
<td>Z38 B18</td>
<td>Missing or illegible procedure or revenue code</td>
</tr>
<tr>
<td>Z41 B18</td>
<td>Missing or illegible ICD procedure code</td>
</tr>
<tr>
<td>Z45 B12</td>
<td>Ambulance runsheet required for processing</td>
</tr>
<tr>
<td>Z47 109</td>
<td>Medicaid fee-for-service</td>
</tr>
<tr>
<td>Z92 5</td>
<td>Invalid or missing place of service</td>
</tr>
<tr>
<td>Z99 B8</td>
<td>Code not payable for provider specialty</td>
</tr>
</tbody>
</table>

### Appendix — supplemental information

- Abortion claims
- Abortion and worker's compensation condition codes
- Acute inpatient psychiatric facility claims
- Adult preventive health claims
- Allergy testing and immunotherapy claims
- Ambulance claims
- Ambulatory surgery claims
- Anesthesia claims
- Autism spectrum disorder (ASD) claims
- Behavioral health claims
- Centering Pregnancy claims
- Chemotherapy claims
- Chiropractic claims
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- Diabetic education claims
- Durable medical equipment (DME) claims
- Early, Periodic, Screening, and Diagnostic Testing (EPSDT) claims
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- Federally qualified health center (FQHC) claims
- Home health care claims
- Infusion therapy and injectable drugs claims
- Laboratory claims
- Maternity claims
- Multiple surgical reduction payment policy
- Newborn claims
- Nursing home claims
- Opioid treatment program claims
- Physical, occupational, and speech therapy claims
- Podiatry claims
- Psychiatric residential treatment facility (PRTF) claims
- Rehabilitative behavioral health claims
- Renal dialysis claims
- Rural health center (RHC) claims
- Smoking cessation claims
- Vision claims
Abortion claims

Therapeutic abortions

Therapeutic abortions and services associated with the abortion procedure are covered only when the physician has found, and certified in writing, that on the basis of his or her professional judgment, the pregnancy is a result of rape or incest or the women suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the women in danger of death unless an abortion is performed.

Therapeutic abortions must be documented with a completed Abortion Statement Form (see the Exhibit section), which will satisfy federal and state regulations. The following guidelines are to be used in reporting therapeutic abortions:

- Since October 1, 2015, the following ICD-10 codes are to be used:
  - O04.5
  - O04.6
  - O04.7
  - O04.80
  - O04.81
  - O04.82
  - O04.83
  - O04.84
  - O04.85
  - Z33.2

- Abortions that are reported with diagnosis and procedure codes for therapeutic abortions must be accompanied by complete medical records that substantiate life endangerment to the mother or that the pregnancy is the result of rape or incest and the signed abortion statement.

- Therapeutic abortion is not considered family planning, and is covered only under certain circumstances.

- The abortion statement must contain the name and address of the patient, the reason for the abortion, and the physician’s name and address. The patient’s certification statement is only required in cases of rape or incest.

- Prior authorization is required. Clinical documentation, a copy of the completed abortion statement and a copy of the police report, if applicable, must be submitted to Select Health’s Medical Affairs department prior to performing the procedure.

Non-elective abortions

All non-elective abortions, including spontaneous, missed, incomplete, septic, hydatidiform mole, require only that the medical record show such a diagnosis. If unable to determine whether the patient was in the process of an abortion from the hospital records, Select Health will ask the hospital to obtain additional physician office or clinic notes and/or ultrasound reports. Medical procedures necessary to care for a patient with ectopic pregnancy are compensable services. The following guidelines are to be used in reporting non-elective abortions:

- Spontaneous, inevitable, or missed abortions should be reported with the appropriate other diagnosis codes (e.g., O01.0, O01.1, and O01.9; O02.81; O02.1; O03.5 and O03.87; O04.5, O04.6. This list is not all inclusive; determination of the appropriate ICD-10 code [for dates of service on or after October 1, 2015] should be based on clinical interpretation).

- Non-elective abortion procedure codes for outpatient hospital are 59812, 59820, 59821, 59830, 59870, and 59200. For inpatient hospital, ICD-10-PCS codes are 0U9900Z-0UD4ZZ, 10D1ZZ-10D18ZZ, 10A7ZW, 3E1J78Z, and 3E1J88Z, based on clinical interpretation to determine the most appropriate conversion code(s) for the specific situation. These procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other non-elective abortions with appropriate diagnosis code.

Billing notes

- Vaginal delivery codes should not be used to report an abortion procedure. The only exception to this rule is when the physician delivers the fetus, the gestation is questionable and there is reasonable probability of survival. The medical record must contain documented evidence that the fetus was delivered by the physician.

- Condition codes are reported in field 10D of the 1500 claim form.

- When billing for any type of abortion, the principal procedure code must be the abortion.

- Legible medical records should be included with all abortions and should include admission history and physical, discharge summary, pathology report, operative report, physician progress notes, and the signed abortion statement form.

- The following diagnosis codes do not require the submission of supporting documentation: O010, O011, and O019; O0281; O021; O364xx0; O4200, O4290, and O42011; O4210, O42111, and O42119. This list is not all inclusive; determination of the appropriate ICD-10 code should be based on clinical interpretation.

Condition codes

The following is the list of condition codes for abortion that are valid for use on the 1500 Health Care Claim Form and in the 837 Professional.

<table>
<thead>
<tr>
<th>Code</th>
<th>Conditions related to abortion claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Abortion performed due to rape</td>
</tr>
<tr>
<td>AB</td>
<td>Abortion performed due to incest</td>
</tr>
<tr>
<td>AC</td>
<td>Abortion performed due to serious fetal genetic defect, deformity, or abnormality</td>
</tr>
</tbody>
</table>
The following is the list of condition codes for workers’ compensation claims that are valid for use on the 1500 Health Care Claim Form and in the 837 Professional.

<table>
<thead>
<tr>
<th>Code</th>
<th>Conditions related to workers’ compensation claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>W2</td>
<td>Duplicate of original bill</td>
</tr>
<tr>
<td>W3</td>
<td>Level 1 appeal</td>
</tr>
<tr>
<td>W4</td>
<td>Level 2 appeal</td>
</tr>
<tr>
<td>W5</td>
<td>Level 3 appeal</td>
</tr>
</tbody>
</table>

These codes have been posted on the NUCC website with the permission of the National Uniform Billing Committee (NUBC).

**Acute inpatient psychiatric facility claims**

Acute inpatient psychiatric facilities provide mental and behavioral health services for members under 21 years of age.

If services are provided immediately before a member reaches age 21, services may continue until the earlier of the date the member no longer requires services or the date the member reaches age 22.

Select Health will adopt the guidelines as outlined in the South Carolina Department of Health and Human Services (SCDHHS) Psychiatric Hospital Services Provider Manual.

**Authorization requirements**

Prior authorization is required for all admissions.
- A Behavioral Health Inpatient fax request form must be submitted to request authorization or requests may be submitted online through the NaviNet provider portal, navinet.navimedix.com/sign-in: Prior Authorization Management
- The Code of Federal Regulations, 42 CFR 441.151, states that inpatient psychiatric services must be certified as necessary, in writing, for the setting in which the services will be provided.
- A SCDHHS Certification of Need (CON) for Psychiatric Hospital Services for Children under 21 form must also be completed for all members under age 21 admitted for acute inpatient treatment services.
- The CON must be completed by an independent review team or the facility-based interdisciplinary team (based on the type of admission) to certify the member’s admission.

**Admission types:**

- **Emergency admission** — immediate admission is necessary to prevent death, cause serious impairment of health, or harm to another person by the member.
  - Facility-based interdisciplinary team must complete the CON form within 14 days of the emergency admission.
  - Emergency admissions must be well documented in the clinical record and must support the claim that the admission was actually an emergency.

- **Urgent admission** — member meets the CON criteria but is not in immediate danger that would cause death, serious impairment to health or bodily harm to another person.
  - CON is completed by the independent review team.

- **Post-Admission** — for members who become Medicaid eligible after admission.
  - The hospital completes the CON form for members who apply for Medicaid while in the facility.
  - The facility-based interdisciplinary team must approve the certification.
  - The CON should cover any period before the Medicaid application was submitted.


Requests may also be submitted via:
- **Phone:** Contact Behavioral Health Utilization Management at 1-866-341-8765
- **Fax:** Complete the Behavioral Health Inpatient fax request form located on the Select Health website and fax it to 1-888-796-5521.
All requests for approvals and denials will be sent to the provider within three calendar days. Select Health Behavioral Health UM provides 24/7 coverage to handle admission requests.

**Co-pays**

- The $25 inpatient admission copay would apply for members over the age of 18 who are not part of a federally recognized Indian tribe and/or pregnant.

**Claims**

Acute Inpatient free-standing Psychiatric facility claims are submitted on the UB04 claim form and will be reimbursed as follows:

- Department of Mental Health (DMH) free-standing psychiatric hospitals will be reimbursed based on the prospective payment system.
- All other free-standing psychiatric hospitals will be reimbursed based on the DRG reimbursement system.
- The following inpatient psychiatric APR-DRGs are payable by Select Health:
  - 7401-7404
  - 7501-7604
  - 7701-7764

For additional information or general questions, contact your Provider Network account executive or the Provider Contact Center at 1-800-575-0418.

**Adult preventive health claims**

Select Health will reimburse for annual exams for adults using these codes:

- 99385: Health screen, ages 18 – 39 (one per year).
- 99386: Health screen, ages 40 – 64 (one per year).

No prior authorization is required for adult preventive health claims.

**Well-woman exam coding considerations:**

- Prior authorization is not required for an annual well-woman exam when performed by a participating provider.
- If you detect a health problem but can still complete the well-woman exam, bill the well exam E/M code and list any additional services necessary to address the problem.
- When billing, use 201411, 201419 (ICD-10) as the first diagnosis.
- The second diagnosis is determined by the detected problem.

**Effective for dates of service July 1, 2019 or after, a sick visit, with a 25 modifier, can be billed on the same date of service as the well woman exam.**

**If the well woman exam cannot be completed, bill only the sick visit.**

**Adult vaccines**

Select Health covers the following vaccines in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) for adult members 19 years of age and older:

- 13-valent pneumococcal conjugate (PCV13).
- 23-valent pneumococcal conjugate (PPSV23).
- Haemophilus influenza type b conjugate vaccine (Hib).
- Hepatitis A (HepA).
- Hepatitis B (HepB).
- Influenza.
- Measles, mumps, and rubella (MMR).
- Measles, mumps, rubella, and varicella (MMRV).
- Rabies.
- Serogroups A, C, W, and Y meningococcal conjugate or polysaccharide vaccine (MenACWY or MPSV4).
- Serogroup B meningococcal (MenB).
- Tetanus and diphtheria toxoids (Td).
- Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap).
- Varicella (VAR).

For more information on specific products covered, refer to the Center for Disease Control CDC) website at www.cdc.gov/vaccines.

When billing for vaccines for members 19 years of age and older, bill for both the vaccine and the immunization administration code. Rabies, Influenza, and Tdap vaccines for adults may be billed through the medical benefit or through the pharmacy. If the pharmacy is billed, then only the administration fee can be billed on the medical side.

**Allergy testing and immunotherapy claims**

**Allergy testing**

Scratch testing is the recommended method for allergy testing and is a covered service. Allergy testing for food allergies is not normally considered medically necessary. Therefore, if the provider is testing for food allergies, they must clearly state the medical necessity and supporting documentation in the member’s medical record.
Allergen immunotherapy

Allergen immunotherapy is performed by providing injections of regular pertinent allergens to the patient to reduce the signs and symptoms of an allergic reaction or prevention of future anaphylaxis. This is usually done with allergen dosages that gradually increase over a period of months.

Providers may bill for professional services for allergen immunotherapy, not including provision of allergenic extracts by billing CPT codes 95115 – 95117. These codes are for professional services only and do not cover reimbursement for antigen extract or venom.

Antigen and preparation

Procedure codes 95144 through 95170 can be used for the supervision, preparation, and provision of antigens for allergen immunotherapy. Providers should not bill for an evaluation and management service on the same day as an allergen injection using CPT codes 95115 and 95117.

Allergy testing and immunotherapy

Allergy testing

The Medicare Physician Fee Schedule Data Base (MPFSDB) fee amounts for allergy testing services billed under codes 95004 – 95078 are established for single tests. Therefore, the number of tests must be shown on the claim.

- Example: If a physician performs 25 percutaneous tests (scratch, puncture, or prick) with allergenic extract, the physician must bill code 95004 and specify 25 in the units field of form CMS 1500 (paper claims or electronic format). The payment amount listed in the fee schedule will be multiplied by the quantity listed in the units’ field.

- Allergy testing under anesthesia and RAST testing are not covered services.

Allergy immunotherapy

All antigen and allergy immunotherapy services are paid for under the Medicare physician fee schedule.

- CPT codes 95120 through 95134 are not valid for Medicare. Codes 95120 through 95134 represent complete services (i.e., services that include both the injection service and the antigen and its preparation).

- Separate coding for injection-only codes (codes 95115 and 95117) and/or the codes representing antigens and their preparation (codes 95144 through 95170) must be used. If both services are provided, both codes are billed. This includes allergists who provide both services through the use of treatment boards.

- If a physician bills both an injection code plus either codes 95165 or 95144, payment will be for the appropriate injection code (i.e., code 95115 or code 95117) plus the code 95165 rate. When a provider bills for codes 95115 or 95117 plus code 95144, code 95144 is changed to 95165 and paid accordingly.

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

Single-dose vials, which should be used only to ensure proper dosage amounts for injections, are more costly than multiple dose vials (i.e., code 95165) and therefore their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple-dose vials. Thus, regardless of whether a single- or multiple-dose vial is billed when an injection service is billed, payment will be at the multiple-dose vial rate.

The fee schedule amounts for the antigen codes (95144 through 95170) are for a single dose. When billing these codes, physicians are to specify the number of doses provided. Payment will be the fee schedule amount multiplied by the number of doses specified in the units’ field.

Allergy shots and evaluation and management (E&M) services on the same day

E&M services should not be billed with allergy injection services 95115 or 95117 unless the visit represents another separately identifiable service. This language parallels CPT editorial language that accompanies the allergen immunotherapy codes, which include codes 95115 and 95117.

The global surgery policies will apply to all codes in the allergen immunotherapy series, including the allergy shot codes 95115 and 95117. The global surgery indicator for allergen immunotherapy code 000 means that the global surgery concept applies, but that there are no days in the postoperative global period.

For a physician to receive payment for a E&M service provided on the same day as a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient’s condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

Services not covered

- Allergy testing under anesthesia and RAST testing.

Authorization requirements

Allergy testing and immunotherapy services do not require prior authorization when rendered by participating providers.
Ambulance claims
All transportation services, advanced life support (ALS) or basic life support (BLS) either emergency or non-emergency, provided via ambulance are payable by Select Health. These trips may be routine or non-routine transports to a Medicaid covered service. Coverage also includes stretcher trips, as well as air ambulance or medivac transportation.

Ground and air ambulance services are billed on CMS 1500 or 837 format.

Documentation requirements
Documentation is necessary to show evidence that billed services were provided and were medically necessary. If during a review sufficient documentation is not available to support the paid claims filed by the provider, then Medicaid funds could be subject to recoupment.

DHEC Run Report
Each time an ambulance service responds to a call, South Carolina law requires that a DHEC-approved Ambulance Run Report be completed to document the trip. The Ambulance Run Report is a medical document that can be used to record a patient’s treatment and must be maintained in the member’s record for all ambulance transports.

ICD-Code
When billing ambulance transportation services, providers must use a valid diagnosis code from the current edition of the International Classification of Diseases, Clinical Modification (ICD-CM) to reflect the current medical condition/problem that requires the transport. Medicaid requires full ICD-CM diagnosis codes.

When billing procedure codes for ambulance transportation services, the provider must also enter a valid two-digit modifier at the end of the associated five-digit procedure code.

- Providers must bill the transport codes with the appropriate destination modifier.
- Claims submitted without a destination modifier will be denied for invalid or missing modifier.
- Mileage must also be billed with the ambulance transport code and be billed with the appropriate procedure codes.
- Mileage when billed will only be paid in conjunction with a paid transport code.
- Providers who bill mileage alone will be denied for invalid or inappropriate billing.
- For 837 claims, all ambulance details are required: ambulance transport information, ambulance certification, and pick-up and drop-off locations.

Procedure code destination modifiers
The following procedure code modifiers are required with all ambulance procedure codes. The first-place alpha code represents the origin, and the second-place alpha code represents the client’s destination. Codes may be used in any combination unless otherwise noted.

- D: Diagnostic or therapeutic site (other than physician’s office or hospital).
- E: Residential, domiciliary, or custodial facility (other than skilled nursing facility).
- EV: Evacuation.
- G: Hospital-based dialysis facility (hospital or hospital-related).
- H: Hospital I - Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport.
- J: Non-hospital-based dialysis facility.
- N: Skilled nursing facility
- NT: No transport.
- P: Physician’s office (includes HMO non-hospital facility, clinic, and other sites).
- R: Residence.
- S: Scene of accident or acute event.
- 76: Duplicate procedure, same day of service.

Authorization requirements for ambulance services
Services requiring authorization
- Hospital to hospital (transfer).
- Transports to doctor’s appointments.
- Hospital or facility discharge.
- Air transport.

Services not requiring authorization
- Emergent and non-emergent ambulance transports, whether ALS or BLS.

Ambulance services not covered
- Ambulance transports requested after the member is pronounced dead
- Ambulance transports to a coroner’s office, morgue, funeral home or any other nonmedical facility
- Free ambulance services
- Convenience transports
- Intra-facility transports.
Inpatient hospital services (offsite). When a member remains an inpatient of the hospital, all services rendered to the member, including ambulance transports, are included in the hospital diagnosis-related group (DRG) payment. (For example, if a member remains on the census as an inpatient at Hospital A and is only traveling to Hospital B for a diagnostic test or procedure not available at A, the DRG facility is responsible). Ambulance providers and the hospital facility should determine payment procedures when rendering services to an inpatient beneficiary.

Ambulatory surgery claims
An ambulatory surgery center (ASC) is a distinct entity that operates exclusively to provide surgical services to patients who are scheduled to arrive, receive surgery, and be discharged on the same day.

Authorization requirements for ASC claims are based on the services performed. Claims must be billed on a CMS 1500 form.

Reimbursement is based on the procedure code billed, with the code generating the highest reimbursement paying at 100 percent of the allowable amount. All other procedure codes will pay at 50 percent of the allowable amount.

Anesthesia claims
Anesthesiology is the study of how to produce loss of bodily sensation.

- Anesthesia is generally administered in an inpatient or short procedure unit (SPU) setting.
- Reimbursement for anesthesia claims is based on the total amount of time the anesthesia was administered to the patient.

All anesthesia services (participating and nonparticipating) are payable without an authorization regardless of the place of service with the exception of pain management. Post-operative pain management rendered on the same date of service as a surgical procedure will not require prior authorization.

Anesthesia providers must bill with the appropriate anesthesia (ASA) procedure code. If a surgical procedure code is billed, the claim will be denied. Anesthesia claims are to be billed with the actual minutes in the unit’s field.

Certified registered nurse anesthetists (CRNAs)
A CRNA is a registered nurse with additional training to administer anesthesia under the direction of the anesthesiologist. CRNAs can be paid in addition to the anesthesiologist. Some CPT codes are payable to anesthesiologists only and not CRNAs.

Modifiers
The following modifiers may be billed with anesthesia services:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesiologist personally performed services.</td>
<td>100 percent of anesthesiology rate</td>
</tr>
<tr>
<td>AD</td>
<td>Medically supervised by a physician for more than four concurrent procedures.</td>
<td>100 percent of anesthesiology rate with standard of three base units</td>
</tr>
<tr>
<td>OK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.</td>
<td>60 percent of anesthesiology rate</td>
</tr>
<tr>
<td>QS</td>
<td>Monitored anesthesiology care services (can be billed by a CRNA or an anesthesiologist).</td>
<td>100 percent of appropriate provider rate</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA with medical direction by an anesthesiologist. This modifier should be billed for CRNAs only.</td>
<td>50 percent of anesthesiology rate</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one CRNA by an anesthesiologist.</td>
<td>60 percent of anesthesiology rate</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA without medical direction by an anesthesiologist. This modifier should be billed for CRNAs only.</td>
<td>100 percent of anesthesiology rate</td>
</tr>
</tbody>
</table>

Autism spectrum disorder (ASD) claims
Select Health provides autism spectrum disorder (ASD) coverage for members under 21 years of age. This benefit includes ASD services rendered by board-certified behavior analysts (BCBAs), board-certified assistant behavior analysts (BCaBAs), and licensed independent practitioners (LIPs) who are approved by South Carolina Department of Disabilities and Special Needs (SCDSSN) to provide evidence-based treatment (an ABA alternative therapy modality).

The following LIPs providers are permitted to render ASD services for Select Health members, once registered with the South Carolina Department of Health and Human Services and Select Health:

- Licensed independent practitioners (LIPs) — masters or doctoral:
  - Licensed psychologist.
  - Licensed psycho-educational specialist (LPES).
  - Licensed independent social worker-clinical practice (LISW-CP).
  - Licensed marriage and family therapist (LMFT).
  - Licensed professional counselor (LPC).

ASD services may also be rendered by school districts that enroll with SCDHHS as ASD group providers.
Autism spectrum disorder (ASD) service array
• Psychiatric Diagnostic Evaluation without Medical — Comprehensive Diagnostic Assessment Initial (90791).
• Psychological Testing and Evaluation (96101).
• Behavior Identification Assessment (0359T).
• Observational Behavior Follow-Up Assessment (0360T, 0361T*).
• Exposure Behavior Follow-Up Assessment (0362T, 0363T*).
• Adaptive Behavior Treatment By Protocol (0364T, 0365T*).
• Adaptive Behavior Treatment With Protocol Modification (0368T, 0369T*).
• Family Adaptive Behavior Treatment Guidance (0370T).

Claims are submitted on a CMS-1500 claim form.

ASD assessment and treatment services are billed using the following procedure codes and frequency limits:

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>Provider type</th>
<th>Unit</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| 97151          | • Board Certified Behavior Analyst — Doctoral level (BCBA-D)  
                 • Board Certified Behavior Analyst — Masters level (BCBA)  
                 • Board Certified Assistant Behavior Analyst (BCaBA)  | 1 unit = 15 minutes | 32 units annually  |
| 97153          | • BCBA-D  
                 • BCBA  
                 • BCaBA  
                 • Registered Behavior Technicians (RBT*) | 1 unit = 15 minutes | 160 units per week (any combination) |
| 97155          | • BCBA-D  
                 • BCBA  
                 • BCaBA | 1 unit = 15 minutes | 64 units per month |
| 97156          | • BCBA-D  
                 • BCBA  
                 • BCaBA | 1 unit = 15 minutes | 24 units per 6 months |
| H2019          | • Licensed Psychologist (PhD)  
                 • Licensed Psychomedical Specialist (LPES)  
                 • Licensed Independent Social Worker, Clinical Practice (LISW-CP)  
                 • Licensed Marriage and Family Therapist (LMFT)  
                 • Licensed Professional Counselor (LPC) | 1 unit = 15 minutes | 4 units per week |

*RBT must bill under a BCBA-D, BCBA, or BCaBA.

Prior authorization:
• Prior authorization is required for all ASD services, including assessments and treatments.

Behavioral health claims
The mental and behavioral health benefit includes the professional and outpatient facility charges associated with the Medicaid covered behavioral health services.

Identifying mental health claims
• For CMS 1500 claims, the CPT code identifies the claim as mental health.
• For UB-04 claims, the ICD diagnosis code identifies the claim as mental health.

Provider types

<table>
<thead>
<tr>
<th>Licensed independent practitioners (LIPs)</th>
<th>Medical professionals</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists</td>
<td>Psychiatrists</td>
<td>Federally qualified health centers (FQHC)</td>
</tr>
<tr>
<td>Marriage and family therapists</td>
<td>Physicians</td>
<td>Rural health clinics (RHC)</td>
</tr>
<tr>
<td>Professional counselors</td>
<td>Nurse practitioners</td>
<td>Acute care hospitals</td>
</tr>
<tr>
<td>Independent social workers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Authorization requirements

Authorization is required for:
• Inpatient psychiatric care.
• Inpatient detoxification or rehabilitative substance abuse care.
• Electroconvulsive therapy (ECT).
• Psychological and neuropsychological testing.
• Environmental intervention.
• Interpretation or explanation of results.
• Individual outpatient therapy sessions (CPT codes 90832, 90834, 90837). Visits over 6 sessions per month for members aged 20 and under.
• Unlisted psychiatric services.
• Services provided by nonparticipating providers.

Authorization is not required for:
• Behavioral health CPT codes rendered by medical professionals.
• Assessment codes and outpatient treatment codes (within the 6-session limitation).

Copays
• The $3.40 office visit copay applies for psychiatric diagnostic assessment with or without medical evaluation, 90791 or 90792 for adults (ages 19 and over) when rendered by medical doctors (MDs) or nurse practitioners (NPs).
• No other copays or deductibles apply for persons receiving behavioral health services.

Labs
All lab services billed by the participating provider are payable without an authorization.

Outpatient behavioral health in the emergency room (ER)
For outpatient services in an ER setting with behavioral health (class C code) primary diagnosis code, the ER visit (both professional and facility fees) are covered.

Inpatient behavioral health diagnosis-related groups (DRGs)
Medical services rendered to patients admitted with a psychiatric diagnosis are payable. The following inpatient psychiatric APR-DRGs are payable by Select Health:

- 7401 – 7404
- 7501 – 7604
- 7701 – 7764

Rural health center and federally qualified health center (RHC/FQHC) behavioral health claims
RHCs and FQHCs can bill behavioral health services and a regular evaluation and management (E/M) encounter on the same date of service.

The RHC and FQHC medical providers (MDs, NPs, and specialists) are not subject to prior authorization requirements when billing behavioral health CPT codes.

The RHC and FQHC LIPS providers (licensed professional counselors [LPC], social workers [SW], psychologists, including psychiatrists and child psychiatrists) must follow the authorization requirements listed above.

Claims are submitted using standard ICD and CPT coding:
• Claims submitted with “T” codes should be denied.
• Claims may be billed using the following place of service codes: 11, 22, 50, or 72.

Behavioral health services covered by Medicaid fee-for-service
All claims in which services are provided or referred by the following state agencies are paid by Medicaid fee-for-service:

• South Carolina School for the Deaf and the Blind
• Sickle Cell Foundation
• Home and Community-Based Waiver Services
• Developmental evaluation centers (DEC)

Chemotherapy claims
Physician’s office
If the entire regimen of chemotherapy is performed in an office setting (lab work, hydration, premedication, and administration of all chemotherapy agents), CPT codes 96401 – 96542 should be billed. These procedures indicate an infusion or injection by the physician or an employee of the physician.

The following are appropriate codes to bill:

• If the patient received chemotherapy over four hours in the office via IV infusion:
  - 96413: Chemotherapy administration, intravenous infusion technique; up to an hour, single or initial substance or drug.
  - 96415: Each additional hour, one to eight hours.
  - J codes: Appropriate medication charges.
• E/M services (CPT codes 99201 – 99215) are allowed when a separate and identifiable medical necessity exists and is clearly documented in the patient’s chart. The physician should not routinely bill an E/M service for every patient prior to chemotherapy administration. Only one E/M service is billable per patient per day.
• Prolonged services (CPT codes 99354 and 99356) may be billed in addition to the E/M code when there is more than an hour of actual face-to-face physician time required beyond the usual service for the level of the E/M code billed. This code should only be used when the physician’s expertise is medically necessary in evaluating and managing the patient over a prolonged period and specific documentation describes the content and duration of the service.
• Critical care services (CPT codes 99291 – 99292) should only be used in situations requiring constant physician attendance of an unstable or critically ill patient. These codes should only be used in situations significantly more complex than other chemotherapy situations.

If a physician or physician group leases space in a clinic or hospital, they may bill for the chemotherapy administration and drugs if all the following criteria are met:
• They are using their own employees, equipment, supplies, and drugs.
• The services are provided in the leased area of the hospital designated as an office.
• The patient is not a registered inpatient or outpatient of the hospital. A physician’s office within an institution must be confined to a separately identified part of the facility used solely as the physician’s office and cannot be construed to extend throughout the entire institution. Services performed outside the office area will be subject to coverage rules applicable to services furnished outside the office setting.
Billing notes

- Infusion start and stop time should be clearly documented. Start time does not include the E/M service or delivery of adjunctive therapy by a nurse or physician.
- Codes 96409 and 96420, chemotherapy administrations, push technique, are only for pushing a chemotherapy agent and are not to be billed when pushing premedications or providing other incidental services.
- Only one push technique code will be allowed per day. These codes cannot be billed when given in a hospital setting.
- If routine maintenance (flushing with heparin and saline) of an access device is the only service rendered, and is rendered by the nurse, the office visit code 99211 is appropriate.
- Therapeutic or diagnostic infusions codes should only be billed when a therapeutic or diagnostic agent other than chemotherapy must be infused over an extended time.
- Payment of these codes is considered bundled into the payment for chemotherapy infusion when administered simultaneously.
- Separate payment is allowed when these services are administered sequentially or as separate procedures. These codes cannot be billed in a hospital setting or in addition to prolonged service codes.
- Blood transfusions may be billed only when the physician or an employee of the physician actually performs the transfusion. It should be billed per unit of blood. If the transfusion requires prolonged physician attendance, then it is appropriate to charge for this service. The medical record must substantiate this service.
- If hospital personnel administer the blood transfusion, it is reimbursable only under the hospital allowable costs. A listing of chemotherapy drug codes can be found in Section 4 of the SCDHHS Physicians, Laboratories, and Other Medical Professionals Provider Manual. Chemotherapy agents provided by a hospital are considered a technical cost and may not be charged by a physician. The hospital is reimbursed for all technical costs.

Inpatient and outpatient hospital services

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under their hospital-based physician Medicaid number.

Chiropractic claims

Chiropractic services are available to all recipients. Chiropractors specialize in the detection and correction of structural imbalance, distortion, or subluxation in the human body. Select Health will cover authorized services up to six visits per state fiscal year (July 1 – June 30).

Authorization requirements

Select Health may require oncology providers to obtain prior authorization for certain chemo and/or other specialty drugs, including injectables.

For a list of drugs that require prior authorization, visit the Select Health website, www.selecthealthofsc.com/pdf/provider/pharmacy/hcpcs-prior-auth-req.pdf.

Prior authorization requests may be submitted via the online prior authorization form, available on the Select Health website at www.selecthealthofsc.com/provider/resources/pharmacy-prior-auth.aspx or by faxing the paper prior authorization form to 1-866-610-2775.

Providers must specify if the request is for a buy and bill medication or if a specialty pharmacy would need to supply the medication.
• Claims identified as Select Health claims at the tip of the CMS 1500 form, even when submitted electronically:
  
  HNS/Select Health
  P.O. Box 2368
  Cornelius, NC 28031

Claim inquiries
To obtain information on outstanding claims (60 days from filing date), complete the HNS fax inquiry form and fax to HNS. The form can be obtained by visiting the HNS website at: healthnetworksolutions.net/HNS%20Forms/HNS%20Fax%20Inquiry%20Form.pdf or in the appendix of this manual.

Be sure to include the member’s names, date of birth, ID number, and dates of service in question, and HNS will research your claim and respond to you within three business days.

Eligibility and benefits inquiry
Be sure to always verify eligibility and benefits for each plan member by contacting Member Services at 1-888-276-2020 or by visiting the NaviNet provider web portal at www.navinet.net. If you are not registered with NaviNet, you can complete the registration when you visit the website.

Provider relations
Questions relating to your participation with Select Health should be directed to your HNS service representative at 1-877-426-2411.

Dental claims
All claims for covered dental services, regardless of the member’s managed care enrollment should be sent directly to DentaQuest for processing.

For dental surgical procedures, providers should submit prior authorization requests to DentaQuest. DentaQuest will review the case for medical necessity and render an approval or denial of the planned procedure being administered in a facility operating room or ambulatory surgery center (ASC) setting. The DentaQuest authorization allows the provider to schedule with the facility. The facility is not required to request a separate authorization from Select Health but is responsible for providing the DentaQuest authorization for care in the facility.

Select Health is responsible for the reimbursement of charges from the facility operating room or ambulatory surgery center and anesthesia associated with dental procedures for our members. Prior authorization is not required for covered codes. However, if the anesthesia code is unlisted, noncovered, or miscellaneous, medical necessity review will be required.

Facility and anesthesia claims should be submitted to Select Health and claims with dental codes should be submitted directly to DentaQuest at:
  
  DentaQuest, LLC — Claims
  P.O. Box 2136
  Columbia, SC 29202-2136

Diabetic claims
Diabetic education is a covered benefit for all members. Providers must be either diabetic program educator (DPE) certified or a Department of Health and Environmental Control (DHEC) office. Diabetic education is not a covered benefit if performed by a nonparticipating or non-DPE-certified provider. For a listing of diabetic education providers in a specific area, go to the Select Health website, www.selecthealthofsc.com, select Providers and then Find a Doctor, and search for diabetic educators in your city and state.

Providers must use specific CPT codes for diabetic education:

• S0315: Disease management program initial assessment and start of the program.
• S0316: Disease management program follow-up or reassessment.
• 9445: Patient education, not otherwise classified, non-physician provider, individual per session.
• S9455: Diabetic management program with education per lifetime. Group session; group size is limited to 12.

Dilated eye, including the refraction, are covered for members with diabetes, regardless of age. Podiatry services billed by a podiatrist are covered for diabetic members 21 and older.

Diabetic supply guidelines
Covered diabetic supplies include:

• Blood glucose meter (glucometer)
  - Maximum of one meter per year (plus one meter for school, if designated on the prescription)
  - ACCU-CHEK® blood guide glucose meter
• Continuous glucose monitor (CGM)
  - Effective 07/01/19, added as a covered DME item for Type 1 diabetes or insulin-dependent pregnant women.
- Lancet strips.
  - Insulin taking: maximum of 100 strips per month.
  - Gestational diabetes: maximum of 300 strips per month.
  - Non-insulin taking: maximum of 50 strips per month.

- Lancing device.
  - Maximum of one device every six months (plus one device for school, if designated on the prescription).

Ketone urine test strips.
- Limited to two 100-count boxes per month; covered under the DME benefit. (HCPC code A4250).

Insulin pumps.
- Insulin pumps are a covered DME benefit for type 1 diabetics only.

Diabetic shoes.
- Diabetic shoes are a covered DME benefit for diabetic members.
- Prescriptions for diabetic shoes must be signed by an MD or Doctor of Osteopathic Medicine (DO).
- Members can receive one pair (two shoes) per year.

**Authorization and copay requirements**
- No authorization is required if the provider is participating and is either DPE certified or a DHEC office.
- Supplies are covered as a DME benefit and are subject to the DME authorization requirements.
- DME items are covered with a prescription or order and a certificate of medical necessity from the PCP or prescribing provider when presented to a participating DME provider.
- A $3.40 copay applies for members 19 and older; there are no copays for members under 19 or pregnant members.

**Durable medical equipment (DME) claims**
DME is equipment and supplies used in the member’s home. Some common examples are:
- Wheelchairs.
- Oxygen concentrators.
- Enteral therapy supplies.
- Adult diapers.
- Prosthetics.
- Orthotics.

**Billing requirements**
- DME is generally billed on a CMS 1500 form.
- Providers may bill for more than one service on a claim.
- Services are billed with HCPCS procedure codes.

**Reimbursement types**
DME equipment is reimbursed as one of the following:
- **Purchase:** Equipment and supplies that are paid in full on receipt, not in monthly increments. Examples of DME purchases are enteral formula, gauze, and tape.
- **Rent-to-purchase:** Equipment that is reimbursed in monthly increments until the purchase price of the item is met. Examples of rent-to-purchase equipment are standard wheelchairs and beds. Equipment is rented for a maximum of 10 months; the item is considered purchased thereafter. Select Health does not reimburse for maintenance fees.
- **Ongoing rental:** Equipment that is reimbursed monthly and does not have a purchase price. Examples of ongoing rentals are oxygen concentrators and ventilators.

**Authorization requirements**
For participating providers, authorization is required for:
- Items with billed charges of $750.00 or greater per DME item.
- DME leases or rentals and custom equipment.
- Diapers/pull-ups (ages 4 – 20) who qualify for quantities over 200/month (for one or both) or brand specific diapers.
- Enteral nutritional supplements and supplies.
- Prosthetics and custom orthotics.
- All unlisted or miscellaneous items, regardless of cost.
- Nonparticipating providers require an authorization for all services regardless of charge.

**Modifiers**
The following modifiers may be billed on DME claims:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RR</td>
<td>Rental</td>
</tr>
<tr>
<td>LL</td>
<td>Lease or rental (applied to purchase)</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
</tr>
<tr>
<td>UE</td>
<td>Used equipment</td>
</tr>
</tbody>
</table>
Enteral therapy
Parenteral, enteral nutrition therapy and feeding supplies are payabe if authorized.

Nebulizers
Nebulizers are covered as purchase only.

Early, Periodic, Screening, and Diagnostic Testing (EPSDT) claims
Select Health participates in the EPSDT program, which benefits children from birth through the month of their 21st birthday. The program provides for the screening of children’s vision, hearing, dental, growth and development, nutrition, and other areas. Screenings can be performed by the member’s PCP, pediatrician, or local health department.

Billing guidelines
EPSDT claims are submitted on the CMS 1500 claim form.
- Claims are billed using CPT procedure codes.
- Do not bill claims using “EPSDT” as the procedure code.
- Labs are paid in addition to the reimbursement for the EPSDT screening.
- Always use preventive health ICD code as the primary diagnosis.
- If a problem is detected use the appropriate ICD diagnosis code as the secondary diagnosis.
- Effective for dates of service July 1, 2019 or after, a sick visit with a modifier 25 can be billed on the same date of service as the EPSDT visit if all the components of the EPSDT exam can be completed. If not, only the sick visit should be billed.

Immunizations
Coding for members 19 and older
- 90471: One immunization.
- 90472: Each additional immunization.

Use 90472 in conjunction with 90471. This code can only be used twice per visit, regardless of the number of additional vaccines administered.

Coding for intra-nasal/oral immunization administration
- 90473: One immunization.
- 90474: Each additional immunization.

Use 90474 in conjunction with 90473. This code can only be used twice per visit regardless of the number of additional vaccines administered.

Coding for members under the age of 19
- 90460: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional, first vaccine or toxoid component (one unit per date of service).
- 90461: Each additional vaccine or toxoid component (two units per date of service).

Additional billing notes
- If you detect a health problem during a well visit and can complete all of the components of the well visit, you may also address the health problem during the same visit. When billing, use preventive health ICD as the first diagnosis. The second diagnosis is then determined by the detected problem.
- If other medically necessary elective tests or procedures (not required elements of the EPSDT visit) are performed during the EPSDT visit, they may be billed additionally. When separate procedures are performed, append a 25 modifier on the EPSDT code.
- All required elements of the EPSDT visit (e.g., a blood pressure check or hearing screening) are included in your reimbursement rate and should not be billed separately.
- You may also bill a sick visit on the same date of service (effective for dates of service July 1, 2019).
- Sports physicals are reimbursable if:
  - All the components of an EPSDT exam are completed.
  - They are billed with EPSDT E/M codes.
  - They are billed with DX codes: Z00121, Z00129, Z0000, Z0001, Z020-Z026, Z0282, Z0289, Z021, Z023, Z008 ICD-10, Z0070, Z0071, Z008
  - Another E/M code is not billed on the same date of service.
  - 97005 (athletic training evaluation) and 97006 (athletic training sports, school, or camp re-evaluation) are not billed.
- Sports physicals are also reimbursable even if a well-child exam was done earlier in the year.
- Laboratory tests are not part of the screening package and may be billed and reimbursed as additional claim lines.
- The screening blood lead test is required as part of EPSDT services. The finger or heel stick collection of the blood sample is covered by the EPSDT rate. However, the lab analysis is covered as a separate service.
  - If your office sends the blood lead samples to an outside laboratory for analysis, the lab should bill directly for the analysis using CPT code 83655.
If your office analyzes the blood lead samples internally, your office should bill for this service using CPT code 83655. You must also include your CLIA number on the claim for any lab services.

- Modifiers 01 and 02 are not required for EPSDT claim submission.
- Primary care providers can bill for topical fluoride varnish treatments, using CPT code 99188, as part of the EPSDT exam.

Claims for VFC vaccine administration must include:
- The appropriate vaccination product CPT code.
- The appropriate vaccination administration code.
- For this code combination, only the administration code will be reimbursable when billing Select Health.
- Federally qualified health centers (FQHCs) and rural health centers (RHCs) must also submit these administration and CPT codes for the vaccination products.

A procedure-to-procedure (PTP) edit affects claims for immunization administration and evaluation and management (E&M) codes performed on the same date of service.

The immunization administration codes affected by the PTP edit are CPT codes in the range of 90460, 90461, 90471 – 90474. All E&M services CPT codes, including preventive medicine services (i.e., well child or EPSDT visits), are impacted by the PTP edit.

Immunization administration codes and E&M services can be reported together when a 25 modifier is appended to the E&M code. Documentation in the medical record should support the use of an appropriate modifier.

When billing for vaccines that are not covered under the VFC program or for beneficiaries over the age of 19, the provider may bill for the vaccine and the administration codes 96372, 90471 – 90474.

**Family planning claims**

Family planning services are pregnancy prevention services for males (vasectomies) and females of reproductive age (usually between the ages of 10 and 55 years).

Family planning services should be billed using the appropriate CPT/HCPCS code with an FP modifier and an appropriate family planning diagnosis code. Services include office visits and exams, preventive contraceptive methods, prescriptions, lab work, and counseling. The family planning modifier (FP) is required on all family planning claims, with the exception of hospital claims.

Medical procedures with family planning implications would not be billed with the FP modifier.

**Sterilization and hysterectomy claims**

Sterilizations and hysterectomy claims require the submission of a consent form with the claim. Therefore these claims should be submitted in hard copy. The consent form is available on the Select Health website at: www.selecthealthofsc.com/provider/resources/forms.aspx

There is a 30-calendar-day waiting period from the date the consent form is signed before the surgery is performed. InterQual criteria will be used for screening prior authorization requests.

Reimbursement for a hysterectomy is not allowed if the hysterectomy is performed solely to render an individual permanently incapable of reproducing. The member’s medical records, Surgical Justification for Hysterectomy form, and the federally mandated Consent for Sterilization form signed by the member are to be provided to Select Health’s Medical Management department prior to performing the procedure.

For urgent and emergent hysterectomy cases (including oophorectomy), the 30-day wait is not required; however, the reason for the procedure must be provided by the physician. The claim will be reviewed retrospectively.

Non-elective, medically necessary hysterectomies must meet the following requirements:
- The individual or her representative must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
- The individual or her representative must sign and date the Consent for Sterilization form prior to the hysterectomy.
- The Consent for Sterilization form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and a description of the nature of the emergency. Please note: medical records may not be substituted for the physician statement.
- Hysterectomy shall not be covered if performed solely to render an individual permanently incapable of reproducing.
- Hysterectomy shall not be covered even if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

Sterilization claims and consent forms are reviewed for compliance with federal regulation (42 CFR 441.250 – 441.259). It is the physician’s responsibility to obtain the consent and submit this form. Sterilization requirements:
• Sterilization is defined as any medical procedure, treatment, or operation done to render an individual permanently incapable of reproducing.

• The individual to be sterilized must give informed consent not less than 30 full calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery), but not more than 180 calendar days before the date of the sterilization. A new consent form is required if 180 days have passed before the surgery is provided.

• The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion, or under the influence of alcohol or other substances that affect the patient’s state of awareness.

• The individual to be sterilized must be at least 21 years old and mentally competent at the time consent is obtained.

• The individual to be sterilized must not be institutionalized (i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed).

• The individual must give informed voluntary consent on the approved Consent for Sterilization form. All questions must be answered and all topics in the consent form discussed. A witness of the patient’s choice may be present during the consent interview.

• The Consent for Sterilization form is not required if the individual was already sterile before the procedure or if the individual required sterilization because of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency. Note: As with hysterectomies, medical records may not be substituted for the physician statement.

• Although hospitals are not required to submit a sterilization consent form with their claim, payment will be recouped if no such documentation is present in Select Health’s records or if the documentation is inaccurate. Hospital providers will be notified in writing and given 30 days to submit the consent form before a recoupment is made.

Authorization and copay requirements

• Prior authorization, referrals, and copays are not required for family planning services, including prescriptions. Family planning pharmaceuticals and devices are not counted toward the adult monthly prescription limit.

• Requests for coverage of hysterectomy procedures require prior authorization.

• Sterilization procedures do not require prior authorization.

Federally qualified health center (FQHC) claims

FQHC services are covered when furnished to patients at the center, in a skilled nursing facility or at the client’s place of residence. Service provided to hospital patients, including emergency room services, are not considered FQHC services.

A billable encounter is a face-to-face, one-on-one service with a physician or mid-level practitioner. Group services should never be billed using the encounter rate. FQHC providers are entitled to a special FQHC encounter rate on the evaluation and management code.

Select Health submits encounter data to the state using standard ICD and CPT coding. Therefore providers must submit claims using standard ICD and CPT coding. Claims submitted with “T” codes will be denied.

FQHC services should be billed using place of service (50) — federally qualified health clinic and under the FQHC NPI number.

Non-FQHC services should be billed under the community-based provider (CBP) NPI number using places of service:

• (21) — Inpatient hospital.

• (22) — Outpatient hospital.

• (23) — Emergency room.

Submit claims for all services provided. Submit claims for all services provided:

• For E/M, diabetic education, including behavioral health codes, use the FQHC NPI number in box 33.

• For services rendered inpatient, at the ER, or skilled nursing facility, laboratory, and SBIRT, use the CBP NPI number in box 33.

• Supplies, lab work, and injections are not billable services. These services and supply costs are included in the encounter rate.

Secondary FQHC claims are coordinated up to the encounter rate; the benefit amount will be the difference between the encounter rate and the other carrier’s payment.

Telemedicine:

• May bill Q3014, telemedicine originating site facility fee, when operating as the referring site. Cannot bill encounter code if these are the only services rendered.

• May bill an encounter code with a GT modifier when operating as the consulting site. (Remember only one encounter code can be billed per date of service.)

Authorization requirements

Standard prior authorization requirements apply depending on the procedure being billed.
Home health care claims
Home health claims comprise the following services: skilled nurse visits, home health aide visits, physical, occupational, and speech therapy visits. Members are entitled to a total of 50 visits per calendar year.

Authorization requirements
The first six home health visits do not require prior authorization. Services rendered after the first six do require prior authorization.

Copays
There is a $3.30 copay for home health services.

Same-day visits
Two nursing care visits performed on the same date of service are payable when billed with procedure code T1030 or T1031 and modifier 76 is indicated on the second visit.

Billable procedure codes
- T1030: Nursing care by a registered nurse
- T1031: Nursing care by a licensed practical nurse
- T1031: Nursing visit to a stabilized patient
- T1028: Assessment visit for a DME evaluation
- T1021: Home health aide visit
- A9900: Supplies
- S9127: Social work services to enhance the effectiveness of home health
- S9128: Speech therapy
- S9129: Occupational therapy
- S9131: Physical therapy

Home infusions and injectable drugs claims
All drugs billed are required to be submitted with National Drug Code (NDC) information and may be submitted via a CMS 1500 or 837 electronic format.

The NDC number and a valid HCPCS code for drug products are required on both the 837 electronic format and the CMS 1500 for reimbursable medications. For 837I claims, submit only one NDC per line; Change Healthcare only considers the first NDC on a claim line. Claims submitted without NDC information will be denied.

Authorization requirements
Visit the Select Health website for a list of medications that require prior authorization at www.selecthealthofsc.com/provider/member-care/pharmacy-prior-auth.aspx.

Laboratory claims
Diagnostic lab services are compensable as separate charges when the provider actually renders the service and CMS’s Clinical Laboratory Improvement Amendments (CLIA) certification standards are met. The CLIA number must be submitted on the CMS-1500 claim form. CMS CLIA regulations apply to laboratory testing in all settings, including commercial, hospital and physician office laboratories.

The appropriate lab service must be coded with a CPT code in the 80000 range. If the provider only extracts the specimen to send to an outside independent laboratory or hospital laboratory, then the physician cannot charge for the lab test. When the specimen is sent to the independent lab or hospital lab, report the patient’s Medicaid number and the lab will bill for their service.

For First Choice members, non-office laboratory services must be submitted through Select Health’s contracted reference laboratory providers. To locate a contracted laboratory, visit the Select Health online provider directory at www.selecthealthofsc.com/provider/self-service/Findadoctor.

Authorization requirements
Any service rendered by a non-contracted laboratory provider requires the ordering provider to obtain prior authorization for the service. First Choice members may not be billed for services provided by a non-contracted lab that are denied due to prior authorization not being obtained.

If prior authorization is not obtained for services provided by a non-contracted laboratory, the claim will be denied.

Claim submission
To help ensure your claims are processed quickly and accurately, please follow the guidelines indicated below:
- For paper claims submitted on the CMS 1500, enter the 10 digit CLIA ID in field 23 (in lieu of the prior authorization number).
- For 837 professional electronic claim submissions, enter your 10 digit CLIA ID number in Loop ID 2300 segment/data element REF02 where REF01 = X4.
- The CLIA number entered must be specific to the location where the provider is performing onsite lab testing.
- Claim payments can only be made for dates of service falling within the particular certification dates governing those services.
- Providers are reminded to add the QW modifier to the procedure code for CLIA-waived tests when required. See www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Categorization_of_Tests.html for more information on CLIA.
Maternity claims

Maternity claims are claims billed by the OB/GYN for prenatal, delivery, and postnatal care.

Authorization requirements

When a member is identified as being pregnant, the OB/GYN is required to obtain an authorization that will cover all OB and postpartum services performed in the office. Providers obtain authorization by submitting a Prenatal Risk Assessment Form, which is in the Exhibits section of this manual and is also available on the Select Health website at www.selecthealthofsc.com in the Provider forms section.

Providers may also submit authorization requests through the NaviNet provider portal.

The Prenatal Risk Assessment Form:

• Should be completed for every pregnant member.
• Helps identify high-risk pregnancies early for case management.
• Is used to create the maternity authorization necessary for payment of prenatal services.

Providers can bill CPT code 96160 and be reimbursed $15 for the completion of this form.

A separate authorization is required for the delivery. The hospital is responsible for obtaining the delivery authorization; however, physician offices should verify that this authorization has been obtained. Prior authorization may be required for other services (e.g., testing) rendered outside of the OB provider’s office. Providers should always check with Medical Services at 1-888-559-1010 for authorization requirements.

Ultrasounds

Three ultrasounds are allowed without authorization for participating providers. Authorization is also not required for four or more ultrasounds, but they require a high-risk diagnosis. This requirement applies to all OB providers, including maternal fetal medical providers.

Makena (17-P) injections

Select Health covers Makena/17-P injections for women who meet the medical necessity criteria. Prior authorization is also required. Please fax the completed Universal Makena/17-P Authorization Form (see the Exhibits section in this manual or visit the website) to 1-866-533-5493 along with a signed prescription. If you have questions, call Medical Services at 1-888-559-1010 and ask for a Bright Start® program representative.

Nurse midwives

Nurse midwives (NMs) are payable under the authorization for the delivery.

Certified nurse midwives (CNMs) are payable at 100 percent of the physician’s rate.

Licensed midwives (LM) are payable at 65 percent of the physician’s rate and should be billed with modifier SB. There are no limitations on postpartum services rendered by a midwife.

Centering Pregnancy claims

Centering Pregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education, and support, into a unified program within a group setting. Women with similar gestational ages meet together, learning care skills, participating in a facilitated discussion, and developing a support network with other group members.

To qualify for reimbursement for Centering Pregnancy group clinical visits, the site must be approved by the Centering Healthcare Institute or be under the Centering grant contract through SCDHHS. In preparation for formal site approval, the provider must provide group prenatal care utilizing the Centering Pregnancy model:

• Group clinical visits must last at least 1.5 hours, with a minimum of two clients and a maximum of 20 clients.
• Up to 10 group clinical visits prior to delivery are covered.
• Providers must use educational materials from the Centering Pregnancy curriculum, and these must be incorporated into the educational portion of the group clinical visit.

Claim submission

Claims are submitted on a CMS-1500 claim form using:

• Code 99078 and modifier TH - group clinical visit for the management of pregnancy.

• The claim must include a pregnancy diagnosis code (ICD-10 series Z34- for normal pregnancy, and ICD-10 series O09- for high-risk pregnancy).

• Must be submitted for the same date of service as claims by the same provider for an established patient visit (E/M procedure codes 99211, 99212, 99213, 99214, or 99215) with modifier TH.

Authorization requirements

• Centering Pregnancy visits do not require a separate authorization; these visits are covered under the outpatient maternity authorization.
Coordination of benefits and copays

For plan members, copays do not apply to maternity services. Select Health does not pay global maternity procedure codes. If the member has a primary insurance that pays based on global maternity codes, Select Health will pay the difference between our maximum allowable for all routine maternity services and the amount paid by the primary carrier for the global maternity service, provided that this difference does not exceed the member’s liability (including copays, coinsurance or deductible, and other amounts).

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a component of the SCDHHS’ Birth Outcome Initiative (BOI) program with the primary goal to improve birth outcomes and overall health of the moms and babies in South Carolina. It is the screening and treatment program for pregnant Medicaid enrollees that addresses the treatment of substance abuse.

Screenings are administered by clinicians:
- Physicians.
- Physician assistants.
- Nurses.
- Social workers.
- Behavioral health therapists.
- Nurse practitioners.
- Medical assistants.

Screenings are performed using the Institute for Health and Recovery Integrated (IHR) Screening Tool. The tool is located in the Exhibits section of this manual and on the Select Health website. Only screenings performed using this tool may be billed. The completed screening from the tool should be maintained in the patient’s medical record.

When making a referral: send completed tool sheet to the plan and referral site. It is no longer necessary to fax all tools — only those requiring referral.

Billing SBIRT services
- Primary DX should be pregnancy related.
- SBIRT codes will only be payable to an OB/GYN or maternal fetal medicine provider.
- Submit claims on the CMS 1500 claim form:
  - Enter the group NPI for the associated practice (field 33A; loop 2010AA).
  - If the provider is the owner or only provider in the practice and only has an individual NPI number, then submit the individual NPI number in both the field 24J or loop 2310B and the field 33A or loop 2010AA.
  - SBIRT codes may be billed in addition to an office visit.

Coding of SBIRT claims

Procedure description code and modifier:
- Screening: H0002
- Positive screen: H0002 HD
- Brief intervention: H0004
- Brief intervention with referral result: H0004 HD

Reimbursement:
- H0002: $24.00, once per year.
- H0004: $48.00, twice per year.

For Select Health, the RHC/FQHC bills CPT/HCPCS codes to the plan, therefore, for SBIRT the FQHC/RHC will submit the H0002 and H0004 codes in addition to the encounter. The primary DX should be pregnancy related.

For smoking cessation visits, services must be one-on-one and face-to-face between the provider and the member.

Code claims with:
- DX code 305.1 — tobacco use disorder.
- Appropriate E&M code:
  - Preventive medicine treatment (99381-99397).
  - New patient codes (99201-99205).
  - Established patient codes (99211-99215).

Services provided by an allied health professional:
- Code up to a level-two office visit (99212).
- Must be billed under the supervising physician’s ID.

For additional information or to set up SBIRT training for your office, contact your Network Management account executive.

Multiple surgical reduction payment policy

Multiple procedures performed at the same operative session are separately reportable and billable. When multiple procedures are performed, the major procedure is submitted without a modifier. Secondary procedures must be submitted with modifier 51 (unless the secondary codes are “add-on” or “modifier 51 exempt” codes).
The procedure code generating the highest reimbursement will be paid at 100 percent of the allowable amount. All other procedure codes will be paid at 50 percent of the allowable amount.

Bilateral procedures are those performed on both the right and left side of the body or organ.

Providers should bill bilateral procedures on two lines using modifier 50 on the second line item.

The procedure code billed without modifier 50 will be paid at 100 percent of the allowable amount and the procedure code billed with the modifier will be paid at 50 percent of the allowable.

Newborn claims
A newborn child of a First Choice mother is automatically enrolled for health care services in First Choice.

The claim for a baby must include the baby’s date of birth and Healthy Connections number — not the mother’s Healthy Connections number.

Nursing home claims
Under the contract between Select Health and SCDHHS, there is a provision that requires MCOs to provide coverage for our members for the first 90 days of continuous confinement in a long-term care facility or nursing home. Additionally, the MCO is responsible for long-term care until the member can be disenrolled at the earliest effective date allowed, at which time payment for long-term care services will be reimbursed at the fee-for-service rate by the Medicaid program. The maximum MCO liability is a total of 120 days.

Authorization requirements
For prior authorization of services, contact Medical Services at 1-888-559-1010.

Claim submission guidelines
- Submit charges on a UB-04 claim form.
- Use revenue codes 120 and 121.
- For claims questions, contact the Provider Claims Service Center at 1-800-575-0418.
- For additional information, contact your Network Management account executive.

Opioid treatment program (OTP) claims
Opioid treatment programs provide evidence-based medication-assisted treatment (MAT) for members with opioid use disorder. Members and facilities have to meet specific requirements to participate in these programs as outlined in the SCDHHS Clinic Services Manual.

Medical necessity must be confirmed and documented in the medical record at time of admission by the physician or advanced practice registered nurse (APRN) who is employed or contracted by the OTP.

Authorization requirements
Prior authorization is not required by Select Health for OTP services.

Copays
There are no co-pays for OTP services.

Claims
Claims are submitted directly to Select Health on a CMS 1500 claim form.

OTPs are reimbursed for the following all-inclusive procedure and assessment codes according to the SCDHHS fee schedule:

- H0047 - Medication-assisted Treatment Initial/Annual Assessment
- H0020 - Methadone Maintenance Treatment
- H0016 - Buprenorphine Maintenance Treatment

For additional information or general questions, contact your Provider Network account executive or the Provider Contact Center at 1-800-575-0418.

Physical, occupational, and speech therapy claims
Therapy services are provided by physicians and specialists in the rehabilitation of physical impairments and disease. Physicians and specialists may bill therapy along with evaluation and management services and/or diagnostic services. Types of therapy include physical, occupational, and speech.

Therapy services are limited to 420 units or 105 hours combined per fiscal year. The fiscal year begins July 1 and ends June 30 of each year. This applies to both private rehabilitative therapy as well as the outpatient hospital clinic therapy.

Authorization requirements
Prior authorization is required after the initial assessment or reassessment. This applies to private and outpatient facility based services.

Podiatry claims
Podiatry services are services medically necessary for the diagnosis and treatment of foot conditions. Services are limited to the specialized care of the foot for members with a diagnosis of diabetes. In-office care includes office visits and routine care, such as nail trimming and corns.
or calluses cutting or removal. Podiatrists must include the appropriate diabetic diagnosis on the claim to ensure payment. In general, podiatry services for members over the age of 21 are noncovered services. However, First Choice adult members with diabetes may receive podiatry services. Diabetic DX must be submitted on the claim.

Authorization requirements

Members under age 21
• No authorization is required for office visits with a participating provider.
• Prior authorization may be required for certain procedures. Providers should verify authorization requirements with Medical Management.
• Nonparticipating providers must obtain prior authorization for all services.

Members ages 21 and older
• No prior authorization is required for participating providers.

Inpatient or outpatient surgical procedures require prior authorization for all members. Providers may obtain prior authorization by contacting Medical Management.

Psychiatric residential treatment facility (PRTF) claims
Select Health provides coverage for services rendered at a psychiatric residential treatment facility (PRTF) for eligible members. This benefit includes inpatient psychiatric care provided to children under age 21. If services are provided immediately before the member reaches age 21, services may continue until the earlier of the date the member no longer requires the services or the date the member reaches age 22.

PRTF services are billed as an all-inclusive per diem rate. All allowable room and board costs, and all professional mental health and/or alcohol/drug use disorder services provided by the professionals employed by the PRTF are included in the per diem rate. All pharmacy-related costs (including psychiatric drugs), injectable medications (including psychiatric injectables), and any state plan services that are not mental health or alcohol and/or drug use disorder services are excluded from the PRTF rate.

PRTF claims:
• Claims for PRTF services are submitted on a UB-04 claim form.
• Revenue codes:
  - 120 — General Semi-Private Room and Board.
  - 124 — Psychiatric Semi-Private Room and Board.
  - 154 — Psychiatric Room and Board — Ward.
  - 183 — Therapeutic Home Time.
  - Services must be billed in increments of no more than 31 days.
  - Claims may be submitted for each member weekly, but should be submitted at least monthly.
  - Claim turnaround time allowed is 30 days from the filing date.
  - If the PRTF bills for services are provided by ancillary providers, claims should be submitted separately on a CMS-1500 claim form.
  - If ancillary services are rendered at the PRTF, place of service is 56 – Psychiatric Treatment Facility. If rendered at the ancillary provider’s office, place of service is 11 – Office.
  - There are no copays or deductibles for members receiving PRTF services.

Prior authorization of PRTF services
• All initial admissions and continued stays require prior authorization. Certain documentation is required for completion of the medical necessity review. For documentation requirements consult the Health Care Professional and Provider Manual located at www.selecthealthofsc.com/pdf/provider/provider-manual.pdf.
• Services will be authorized up to 30 days.
• Prior authorization requests will be completed within seven calendar days of receipt of all necessary documentation.
• If members are transitioning from another managed care plan, Select Health will honor the days remaining in other plan’s authorization.

Rehabilitative behavioral health claims
Select Health provides coverage for rehabilitative behavioral health services (RBHS). RBHS are medical or remedial services that are recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability and restoration of a member to his or her best possible functional level. RBHS includes the following categories:
• Behavior modification: Used to provide the member with redirection and modeling of appropriate behaviors to enhance function in the home and/or community.
• Psychosocial rehabilitative services: Intended as a skill-building service, not a form of psychotherapy or counseling.
• Family support services: Used to enable the family or caregiver to be an engaged member of the treatment team and/or improve their ability to care for the member.
• Community integration services: Targeted treatment service for adults ages 18 years and older with serious and persistent mental illness.
• Therapeutic child care: Targeted treatment services for children under age 6 years, who have experienced trauma, neglect, and abuse and are in need of early intervention.
The addition of this benefit will also include covering services rendered by state and other public agencies that previously did not participate in the Select Health provider network. This includes such providers as the Department of Mental Health (DMH), Department of Juvenile Justice (DJJ), and Department of Education.

Authorization requirements
The following RBHS services will require prior authorization.

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>Procedure code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96101*</td>
<td>Psychological testing, per hour, psychologist or physician, face-to-face, interpretation and report</td>
</tr>
<tr>
<td>96102*</td>
<td>Psychological testing with qualified health care professional interpretation and report, administered by technician, per hour, face-to-face</td>
</tr>
<tr>
<td>96110*</td>
<td>Developmental testing, limited with interpretation and reporting</td>
</tr>
<tr>
<td>96111*</td>
<td>Developmental testing, extended</td>
</tr>
<tr>
<td>96116*</td>
<td>Neurobehavioral status exam, per hour, psychologist or physician, face-to-face, interpretation and report</td>
</tr>
<tr>
<td>96118*</td>
<td>Neuropsychological testing, per hour, psychologist or physician, face-to-face, interpretation and report</td>
</tr>
<tr>
<td>96119*</td>
<td>Neuropsychological testing with qualified health care professional, interpretation and report, administered by technician, per hour, face-to-face</td>
</tr>
<tr>
<td>H0010</td>
<td>Alcohol and/or drug services, sub-acute detox (residential addiction program, inpatient)</td>
</tr>
<tr>
<td>H0011</td>
<td>Alcohol and/or drug services, acute detox (residential addiction program, inpatient)</td>
</tr>
<tr>
<td>H0015</td>
<td>Alcohol and/or drug intense outpatient</td>
</tr>
<tr>
<td>H0018</td>
<td>Alcohol and other drug (AOD) short-term residential (American Society of Addiction Medicine [ASAM])</td>
</tr>
<tr>
<td>H0019</td>
<td>AOD long-term residential (ASAM)</td>
</tr>
<tr>
<td>H0038</td>
<td>Peer support services (PSS)</td>
</tr>
<tr>
<td>H2014</td>
<td>Behavior modification</td>
</tr>
<tr>
<td>H2017</td>
<td>Psychosocial rehabilitation services (PRS)</td>
</tr>
<tr>
<td>H2030</td>
<td>PRS (clubhouse or community integration services [CIS] — adults)</td>
</tr>
<tr>
<td>H2035</td>
<td>Alcohol and/or drug treatment program, per hour</td>
</tr>
<tr>
<td>H2037</td>
<td>Developmental delay preventive, 15 minutes (therapeutic child care [TCC])</td>
</tr>
<tr>
<td>S9482</td>
<td>Family support</td>
</tr>
</tbody>
</table>

*Note: The psychological and neuropsychological testing codes will be updated once final updates are received from SCDHHS.

Claim submission guidelines
Rehabilitative behavioral health providers are set up in the Select Health system as facilities. Therefore when submitting claims for services, all of the standard claims requirements apply and RBHS providers must submit:

- The facility NPI number in box 24J instead of an individual provider’s NPI.
- Payee information in box 33, facility NPI in box 33a, and RBHS Taxonomy code in box 33b.

Renal dialysis claims
Renal dialysis is a form of medical treatment that removes the body’s wastes and excess water directly from the blood. Select Health’s plan members may receive renal dialysis for the treatment of end-stage renal disease (ESRD).

ESRD refers to a stage of kidney damage at which clinical intervention is required. If there is no clinical intervention, the patient will expire. Patients with ESRD are faced with two treatment alternatives. The first alternative is a kidney transplant. Due to the lack of donor kidneys, most patients choose renal dialysis.

Dialysis claims must be billed on a CMS 1500 form. Providers are not required to submit an itemized claim.

Dialysis may be administered in an inpatient or outpatient hospital setting or in a dialysis clinic (POS 65).

Authorization requirements
Renal dialysis services and treatments do not require an authorization, regardless of the provider’s participation status. However, authorization may be required for some dialysis-related J codes. For a list of medications that require prior authorization, visit the Select Health website at: [www.selecthealthofsc.com/provider/member-care/pharmacy-prior-auth.aspx](http://www.selecthealthofsc.com/provider/member-care/pharmacy-prior-auth.aspx). The J codes must also be billed with the National Drug Code (NDC) number and drug name. These requirements apply to both participating and nonparticipating providers.

Rural health center (RHC) claims
For rural health centers (RHCs), Select Health providers are required to submit claims using standard ICD and CPT coding because Select Health submits encounter data to the state using standard ICD and CPT coding. Claims submitted with “T” codes will be denied.

RHC services should be billed using the place of service (72) — rural health clinic. For lab and other non-RHC services, the following place of service codes should be billed:

- Office (11).
- Outpatient hospital (22).
- Inpatient hospital (21).
- Emergency room (23).

Rural health center (RHC) claims
For rural health centers (RHCs), Select Health providers are required to submit claims using standard ICD and CPT coding because Select Health submits encounter data to the state using standard ICD and CPT coding. Claims submitted with “T” codes will be denied.

RHC services should be billed using the place of service (72) — rural health clinic. For lab and other non-RHC services, the following place of service codes should be billed:

- Office (11).
- Outpatient hospital (22).
- Inpatient hospital (21).
- Emergency room (23).
Submit claims for all services provided:

- E/M, including behavioral health, immunizations, and administration codes — Use the RHC NPI number in box 33. Remember to include NDC numbers for immunization products.
- Services rendered inpatient, at the emergency room, or skilled nursing facility, laboratory, and SBIRT charges are not considered RHC services — Use the group NPI number in box 33.

Coding considerations

RHC providers may bill:
- Codes 90654 – 90688, Q2035 – Q2039 for adult flu vaccines, ages 19 and above.
- The technical component of electrocardiograms (EKGs), non-stress tests, and X-rays.
- Q3014, telemedicine originating site facility fee. Cannot bill an encounter code if these are the only services being rendered.
- May bill an encounter code with a GT modifier, when operating as the consulting site. (Remember only 1 encounter code can be billed per date of service.)

Authorization requirements

Standard prior authorization requirements may apply, depending on the procedure being billed.

Smoking cessation counseling claims

Select Health provides tobacco cessation coverage (under the medical benefit).

Smoking cessation products:
- Zyban (generic bupropion) — quantity limit of 60 per 30 days.
- Chantix (varenicline) — quantity limit of 60 per 30 days.
- Nicotine gum — quantity limit of 480 pieces per 30 days.
- Nicotine lozenges — quantity limit of 480 pieces per 30 days.
- Nicotine patches — 7 mg and 21 mg patches 30 patches per 30 days; 14 mg patch 30 patches per 30 days.
- Nicotine nasal spray — quantity limit of 3 systems per 30 days.
- Nicotine inhaler — quantity limit of 3 systems per 30 days.
- Zero copay.

The following combination therapies are also covered:
- Long-term nicotine patch plus other NRT product (gum or spray)
- Nicotine patch plus nicotine inhaler
- Nicotine patch plus bupropion SR

Smoking cessation claims

- Tobacco cessation counseling in individual and group settings will be covered when billed using codes:
  - 99406 — smoking and tobacco use cessation counseling visit, intermediate, greater than 3 minutes up to 10 minutes.
  - 99407 — smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes.
- Reimbursement for counseling is limited to 4 sessions per quit attempt for up to 2 quit attempts annually.

Prior authorization:
- Counseling sessions — prior authorization is not required regardless of participation status.
- Smoking cessation products — prior authorization is not required.

Vision claims

Routine vision services are covered for First Choice members under the age of 21 years. Routine vision services include all of the following:
- Refraction.
- Initial and replacement glasses for members under age 21.
- Fitting and dispensing fees.
- Eyeglasses.

Robertson’s Optical is the sole provider for eyeglasses. Robertson’s Optical will submit the claim for the eyeglasses. For more information or questions regarding eyeglasses, contact Robertson’s Optical directly at 1-800-922-5525.

Vision services with a medical diagnosis (disease of the eye — glaucoma, conjunctivitis, and cataracts) are covered for members of all ages. The office visit copay applies for members ages 19 and over. For diabetic members, the exam including the refraction component is covered. However, diagnosis codes in the H52-H53 range are excluded from coverage. Using these diagnoses will cause denials. Claims must be submitted with a diabetic diagnosis code as primary and applicable vision-related diagnosis codes secondary. If a routine exam diagnosis code is used, the claim may not be paid.

Authorization requirements

- Prior authorization is not required for routine vision services for participating providers.
- Prior authorization is not required for eyeglasses.
- Prior authorization is required for contact lenses.
- Prior authorization is required for all services rendered by nonparticipating providers.
# Most common CMS 1500 Claim Form errors

## CMS 1500 (02/12) Claim Form most common errors

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Error description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Patient's Name (Last, first, middle initial)</td>
<td>Patient name is missing or illegible.</td>
<td>Patient's name must be entered as it appears on the member’s ID card. For a newborn without a name, enter “Baby Girl” or “Baby Boy” and last name.</td>
</tr>
<tr>
<td>3</td>
<td>Patient Sex</td>
<td>Patient's sex is required.</td>
<td>Patient's sex must be entered as “M” or “F.”</td>
</tr>
<tr>
<td>4</td>
<td>Insured's Name</td>
<td>Insured's name is missing or illegible.</td>
<td>Patient's date of birth must be entered. Month, day, and year must match the plan's system.</td>
</tr>
<tr>
<td>5</td>
<td>Patient Address</td>
<td>Patient address is missing or illegible.</td>
<td>Enter the patient's complete address and phone number. (Do not punctuate the address or phone number.)</td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship</td>
<td>Patient relationship to insured is required.</td>
<td>Always indicate self.</td>
</tr>
<tr>
<td>7</td>
<td>Insured's address</td>
<td>Insured's address is missing or illegible.</td>
<td>Enter the street number, street name, city, state, ZIP code, and phone number.</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates (related to current services)</td>
<td>Dates of services (DOS) are missing or illegible.</td>
<td>Enter the From and To DOS.</td>
</tr>
</tbody>
</table>
| 22           | Resubmission Code                  | For corrected or voided claims, resubmission code “7” or “8” must be entered. | Enter one of these resubmission codes:  
  - 7: Correction or replacement of a prior claim  
  - 8: Void or cancel a prior claim  
  Also include the original claim number. |
| 24E          | Diagnosis Pointer                  | Diagnosis pointer is required.                         | Enter 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. |
| 24F          | Line Item Charge                   | Line item charge amount is missing.                   | A value must be indicated for each line item entered. |
| 24G          | Days/Units                         | Days and units are required.                           | Enter quantity. Value entered must be greater than zero (field allows up to three digits). |
| 26           | Patient Account                    | Patient account or control number is missing or illegible. | The provider's patient account or control number must be entered. |
| 27           | Assignment                         | Assignment acceptance must be indicated on the claim.  | “Yes” or “No” must be checked. |
| 33           | Billing Provider Name and Address  | Billing provider name and/or address is missing or illegible, or a P.O. box was entered. | The billing provider's name and address are required. A physical location must be entered. P.O. boxes are not acceptable. |

# Most common UB-04 Claim Form errors

## UB-04 Claim Form most common errors

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field description</th>
<th>Error description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Billing Provider, Name, Address, and Phone Number</td>
<td>Billing provider name and/or address is missing or illegible, or a P.O. box was entered.</td>
<td>The billing provider's name and address are required. A physical location must be entered; P.O. boxes are not acceptable.</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Account/Control Number</td>
<td>Patient account or control number is missing.</td>
<td>Enter the provider's patient account or control number.</td>
</tr>
<tr>
<td>14</td>
<td>Admission Type</td>
<td>Admission type is required.</td>
<td>Enter a code indicating the priority of the admission or visit.</td>
</tr>
<tr>
<td>15</td>
<td>Source of Referral for Admission</td>
<td>Source of referral is missing.</td>
<td>Enter a code indicating the source of the referral for this admission or visit.</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour</td>
<td>Discharge hour is required.</td>
<td>Enter a code indicating the discharge hour of the patient from inpatient care.</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>Revenue code is missing or illegible.</td>
<td>Enter codes that identify specific accommodation, ancillary service, or unique billing calculations or arrangements. On the last line, enter 0005 for the total. Refer to the Uniform Billing Manual for a list of revenue codes.</td>
</tr>
<tr>
<td>53</td>
<td>Assignment of benefits certification indicator is missing.</td>
<td>Assignment of benefits certification indicator is required; valid entries are “Y” (yes) or “N” (no).</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>Patient's Reason for Visit</td>
<td>Reason for patient visit is missing.</td>
<td>Enter the ICD diagnosis codes describing the patient's reason for the visit at the time of outpatient registration. This is required for all outpatient visits. Up to three ICD codes may be entered.</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Qualifier</td>
<td>Attending qualifier is missing or invalid.</td>
<td>Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and the physician’s name in the lower line. If the attending physician has another unique ID number, enter the appropriate desribes two-digit qualifier, followed by the other ID number. Enter the last name and first name of the attending physician.</td>
</tr>
</tbody>
</table>

**Note:** Claims missing these form elements are subject to rejection.
Exhibits

- 2019 Prior Authorization Information Chart
- Abortion Statement
- CMS 1500 Form
- Consent For Sterilization Form
- HNS Fax Inquiry Form (Chiropractic)
- HNS Notification of Change Form
- Institute for Health and Recovery Integrated (IHR) Screening Tool (SBIRT)
- Pregnancy Risk Assessment Form
- UB-04 Claim Form
- Universal 17-P Authorization Form
2019 Prior Authorization Information chart (page 1 of 2)

**Services requiring prior authorization**

- Air ambulance
- All out-of-network services (with exceptions noted under "Does Not Require Authorization")
- All unlisted miscellaneous and manually priced codes (including, but not limited to, codes ending in "99")
- Autism spectrum disorder (ASD) services
- BabyNet services
- Behavioral health (psychological and neuropsychological testing, electroconvulsive therapy, environmental intervention, interpretation or explanation of results, unlisted psychiatric services)
- Behavioral health individual outpatient therapy sessions (CPT codes 90832, 90834, 90837). Visits over 6 sessions per month for members aged 20 and under.
- Biogastric and 2-6 fl. sequence and duplication/deletion gene analysis
- Chronic care (six visits per fiscal year, July 1 through June 30)
- Cochlear implantation
- Contact lenses (including dispensing fees)
- DADAS services (handled services and some discrete services)
- Gastric bypass/vertical band gastropasty
- Hyperbaric oxygen
- Hysteroscopy (Hysteroscopy Consent form required) — elective abortions
- Implants (over $750)
- Mastectomy
- Maxillofacial (all codes applicable)
- Pancreatectomy
- Penile prosthesis
- Plastic surgery/cosmetic dermatology
- Reduction mammoplasty
- Septoplasty
- 2019 Prior Authorization Information chart (page 2 of 2)

**Pharmacy and medications**

List of HCPCS codes that require prior authorization is available at www.selecthealthofsc.com

- Medications not listed on the South Carolina Medical Professional Services Fee Schedule are not covered by a plan.
- Just-in-time and pre-authorization for more than 100 days/month (for 3000-4000 codes)
- Just-in-time and pre-authorization for more than 300 days/month (for 90832, 90834, 90837)
- Members ages 21 and under require prior authorization for more than 300 days/month of all combined individual therapy sessions (codes 90832, 90834, 90837)
- Members ages 21 and older — benefit limitation of 72 sessions/fiscal year for all combined individual therapy sessions (codes 90832, 90834, 90837)
- Members ages 21 and older — benefit limitation of 72 sessions/fiscal year for all combined individual therapy sessions (codes 90832, 90834, 90837)
- Behavioral health and substance use disorder outpatient therapy
- Behavioral health — crisis intervention: Behavioral Health Services requiring notification

**Does not require authorization**

- All newborn deliveries
- Maternity obstetrical services (after first visit) and outpatient care (includes 48-hour observation)
- Behavioral health — crisis intervention notification required (within 2 business days) post-service. Medical necessity review required after 90 days post-service to validate the request.
- Low-level plain films — X-rays, electrocardiograms (ERGs)
- Family planning services
- Post-stabilization services (in-network and out-of-network)
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Women’s health care in-network providers (OB/GYN services)
- Routine vision services
- Post-operative pain management (must have a surgical procedure on the same date of service)
- Behavioral health and substance use disorder outpatient therapy
- Pain management
- Behavioral health — crisis intervention notification required (within 2 business days) post-service. Medical necessity review required after 90 days post-service to validate the request.
- Low-level plain films — X-rays, electrocardiograms (ERGs)
- Family planning services
- Post-stabilization services (in-network and out-of-network)
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Women’s health care in-network providers (OB/GYN services)
- Routine vision services
- Post-operative pain management (must have a surgical procedure on the same date of service)
- Behavioral health and substance use disorder outpatient therapy
- Pain management
Abortion Statement

This certification meets FFP requirements and must include all of the aforementioned criteria.

Member Information

Member name: ________________________________ First Choice ID #: __________________
SSN: ____________ Date of birth: ______________
Member address: ____________________________ City, State ZIP: ____________ Phone: ____________

Provider Information

Name (include credentials): ____________________________ NPI #: __________________
Phone: ____________ Fax: ____________
Address: ____________________________ City, State ZIP: ____________
Contact person name: ____________________________ Contact email: __________________
Contact phone: ____________

Physician Certification Statement

I, ____________________________ certify that it was necessary to terminate the pregnancy of ____________________________ for the following reason:

a. Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: ____________________________

b. The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

Provider signature: ____________________________ Date: ____________

Patient Certification Statement

I, ____________________________, certify that my pregnancy was the result of an act of rape or incest.

Member signature: ____________________________ Date: ____________
Consent For Sterilization Form (page 1 of 2)

Statement Of Person Obtaining Consent

Before_________________________ signed the consent form, I explained to him/her the nature of sterilization operation

Specific type of operation

the fact that it is intended to be a final and irrevocable procedure and the discomforts, risks and benefits associated with it.

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

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

Signature of person obtaining consent

Military Address

Physician's Statement

Shortly before I performed a sterilization operation upon__________________________

Specific type of operation

the fact that it is a Specific Type of Operation intended to be a final and irrevocable procedure and the discomforts, risks and benefits associated with it.

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

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

Signature of person obtaining consent

Statement For Sterilization Form (page 2 of 2)

Paperwork Reduction Act Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary, however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 505 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.

HNS Fax Inquiry Form

<table>
<thead>
<tr>
<th>PROVIDER'S INFORMATION</th>
<th>HNS TO COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today’s Date:</td>
<td>Date Received by HNS:</td>
</tr>
<tr>
<td>Provider's Name: Dr.</td>
<td>Date Response Sent:</td>
</tr>
<tr>
<td>Fax</td>
<td>Response Prepared By:</td>
</tr>
<tr>
<td>Phone</td>
<td>Fax Number: (877) 329-2620</td>
</tr>
<tr>
<td>Number of Pages:</td>
<td>Number of Pages:</td>
</tr>
<tr>
<td>Contact Person:</td>
<td>HNS Provider Rep:</td>
</tr>
</tbody>
</table>

- Should claims for the attached member ID card be filed to HNS?
- What information from the attached member ID card should be in boxes 11, 11b, & 11c?
- Change of Practice Information – please fax a Change Form to our office.
- The patient and date of service circled on the attached EOB (and remittance statement) isn’t a patient at this office. Please adjust accordingly.
- Please check the status of the following primary claim(s). Has HNS received the claim(s)?
- Please check the status of the following secondary claim(s). Has HNS received the claim(s)?

<table>
<thead>
<tr>
<th>Name:</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID #:</td>
<td>ID #:</td>
</tr>
<tr>
<td>Ins Plan:</td>
<td>Ins Plan:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Date(s) of Service:</td>
<td>Date(s) of Service:</td>
</tr>
</tbody>
</table>

Visit our website at http://www.healthnetworksolutions.net

HNS Notification of Change Form (page 1 of 4)

Instructions:

1. Please print or type clearly
2. W-9 Form: As indicated below, all type 2 changes require the submission of a newly completed W-9 Form.
3. Please fax the appropriate pages of the HNS Notification of Change Form (and W-9, if applicable) to HNS at (877) 329-2620

Please review the types of change(s) below, determine the correct form to complete, and then follow the instructions provided.

**Type 1 Changes** (W-9 not required)
For Type 1 changes, please complete page 2 and fax to HNS.
- Change to telephone number
- Change to fax number
- Change to billing information (mailing address, telephone, fax, email or billing software)

**Type 2 Changes** (requires submission of new W-9)
For type 2 changes, please complete pages 3 and 4 and fax to HNS together with a completed W-9 form.
- Change to legal name of practice
- Change to DBA of practice
- Change to provider’s name
- Changes regarding your Type 2 NPI number
- Change of practice address
- Change to Tax ID / EIN

**Please Note:** Electronic payments (EFT) from HNS are linked to your EIN. If you have changed your EIN you must update your EFT registration on the secure portion of the HNS website with your new EIN to ensure HNS payments are deposited into the appropriate bank account.
HNS Notification of Type 1 Changes

HNS is responsible for ensuring we maintain accurate information regarding all participating providers in the network and for promptly notifying contracted payors of any changes regarding participating providers. Please complete the following pages and fax this form, and if indicated, a completed W-9 form, to HNS. Please do NOT notify payors of any changes. On your behalf, HNS will notify payors of the changes.

Date: ______________________   Effective date of change: _____________________

Type 1 Changes - (W-9 Form is NOT required)

Please check the appropriate change(s) below:

_______ Change to telephone number
_______ Change to fax number
_______ Change to billing information (mailing address, telephone, fax, email, software)

Name of Provider: _________________________________________________________________
(Last)                                 (First)                                                (M)

Type 1 NPI: ___________________________________ 

Please type or print your NEW information below:

Telephone number:________________________
Fax number: _____________________________
Change to billing information (mailing address, telephone, fax, email, software):

Billing Address (only submit change to HNS if billing address is different from practice physical address):

County:

Billing phone number: ___________________________
Billing Fax number: ___________________________

Billing Software: ___________________________
Billing Contact: ___________________________
Billing Email address: ___________________________

List ALL Providers practicing at this location:

<table>
<thead>
<tr>
<th>Name of provider</th>
<th>Type 1 NPI</th>
<th>TAX ID (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

For Type 1 changes: Please fax ONLY this page to HNS
Fax: (877) 329-2620

HNS Notification of Type 2 Changes

HNS is responsible for ensuring we maintain accurate information regarding all participating providers in the network and for promptly notifying contracted payors of any changes regarding participating providers. Please complete the following pages and fax this form, and if indicated, a completed W-9 form, to HNS. Please do NOT notify payors of any changes. On your behalf, HNS will notify payors of the changes.

Date: ______________________   Effective date of change: _____________________

Type 2 Changes (New W-9 Required)

For all Type 2 changes, you must complete Sections A and B and submit a current W-9 form. (W9 forms are posted on the HNS website, under HNS Forms.)

Please check ALL of the applicable change(s) below:

_______ Change to legal name of practice
_______ Change to DBA of practice
_______ Change to provider’s name
_______ Changes regarding your Type 2 NPI number
_______ Change of practice address
_______ Change to Tax ID / EIN

Section A - Previous Information:
Please provide the following regarding your previous practice information.

Provider Name: ______________________________________________________________________
(Last)                                     (First)                                                     (M)
Legal name of practice: ____________________________________________ _____________ _______
DBA: _____________________________________________________ _________________________
Provider Type I NPI: _____________________Provider Type II NPI: _____________________
Tax ID / EIN: ___________________________Provider’s Email Address: ___________________________

Practice Information
Practice Physical Address:

County:

Office phone number: ___________________________
Office fax number: ___________________________
Office Contact: ___________________________
List ALL Providers practicing at this location:

<table>
<thead>
<tr>
<th>Name of provider</th>
<th>Type 1 NPI</th>
<th>TAX ID (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section B - New Information
Please provide the following regarding your NEW practice information

Provider Name: ____________________________ (Last) ____________________________ (First) ____________________________ (M)

DBA: ____________________________________________________________________________

Provider Type I NPI: __________________ Provider Type II NPI: ____________________________

Tax ID / EIN: __________________________ Provider’s Email Address: ____________________________

Please Note: Electronic payments (EFT) from HNS are linked to your EIN. If you have changed your EIN you must update your EFT registration on the secure portion of the HNS website with your new EIN to ensure HNS payments are deposited into the appropriate bank account.

Practice Information

Practice Physical Address: ____________________________ County: ____________________________

Office phone number: ____________________________ Office fax number: ____________________________

List ALL Providers practicing at this location:

<table>
<thead>
<tr>
<th>Name of provider</th>
<th>Type 1 NPI</th>
<th>TAX ID (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For Type 2 changes Please fax pages 3 and 4 to HNS, together with a newly completed W-9 form
Fax: (877) 329-2620.

### ADVICE FOR BRIEF INTERVENTION

**At Risk Drinking**

<table>
<thead>
<tr>
<th>T</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Non-Pregnant**

1. Drink 3+ drinks/week
2. Drink 3+ drinks/day

**Pregnant/Planning Pregnancy**

1. Drink 3+ drinks/week
2. Drink 3+ drinks/day

**Any Use is Risky Drinking**

**CONFIDENTIAL SBIRT REFERRAL INFORMATION**

Patient referred to: [ ] Domestic violence [ ] DMH [ ] DAIDSAS [ ] DHEC Outline [ ] Private provider (Name & NPI)

Date of referral appointment (DD/MM/YY): ____________________________ Date screened: ____________________________

Patient refused referral: ____________________________ Referral not warranted: ____________________________

Patient requested assistance: ____________________________

Women’s health can be affected by emotional problems, alcohol, tobacco, other drug use and domestic violence. Women’s health is also affected when those same problems are presented in people close to us. By “alcohol,” we mean beer, wine, wine coolers or liquor.

Physician’s Signature: ____________________________

*Adapted from Institute for Health & Recovery, (2012)*
## Pregnancy Risk Assessment Form

### Pregnancy Risk Assessment Information

Please fax this form to Select Health of South Carolina at 1.866.533.5493. If you have questions, please call Bright Start at 1.888.559.1010.

#### Provider Information
- Provider name
- Tax ID #
- Address
- Phone

#### Member Information
- Member Name
- Medicaid ID #
- Address
- Email
- Date of birth
- Language preferred
- Phone

#### Tobacco Use
- Pre-Pregnancy
- 1st Trimester
- 2nd Trimester
- 3rd Trimester

#### Average number of cigarettes smoked per day
- Preconception
- 1st trimester
- 2nd trimester
- 3rd trimester

#### Smoking History
- If none, enter 0; 1 pack = 20 cigarettes

#### Pregnancy Information & History
- Date of first prenatal visit
- 17P Candidate
- Yes
- No

#### Last Pregnancy
- Low birth weight < 2500 grams
- Previous Cesarean Section
- Pre-term delivery (gest. age:)
- Congestive Heart Failure
- Other (specify)

#### Current Pregnancy
- Multiple gestation:
  - Twins
  - Triplets
  - Other:
- Pre-eclampsia
- Eclampsia
- Preterm labor
- Diabetics
- Obstetric disease
- Eclampsia
- Other (specify)

#### Active Mental Health Conditions
- No mental health conditions
- Schizophrenia
- Bipolar
- Depression

#### Social, Economic and Lifestyle Issues
- No identified social, economic or lifestyle issues
- Opioid therapy
- Substance abuse (specify type)

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Please call Bright Start or fax an updated form if the member has any changes in condition during pregnancy. This updated information can assist Bright Start with member outreach.

Select Health Bright Start | PO Box 40849 | Charleston, SC 29423 | Toll free: 1.888.559.1010 | Fax: 1.866.533.5493 | www.selecthealthofsc.com
## Universal 17-P Authorization Form

*Fax the COMPLETED form or call the plan with the requested information.

### Claims Information

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Phone Number, Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute Total Care</td>
<td>803-933-3889, 866-902-1689</td>
</tr>
<tr>
<td>BlueChoice HealthPlan</td>
<td>866-559-1010 (Toll Free)</td>
</tr>
<tr>
<td>First Choice by Select Health</td>
<td>888-588-9842</td>
</tr>
<tr>
<td>WellCare Health Plan, Inc.</td>
<td>866-354-8709</td>
</tr>
<tr>
<td>Advicare</td>
<td>888-781-4316, 800-823-5520</td>
</tr>
<tr>
<td>Molina Healthcare, Inc.</td>
<td>888-559-1010 (Toll Free)</td>
</tr>
<tr>
<td>WellCare Health Plan, Inc.</td>
<td>866-781-4371, 800-533-5493</td>
</tr>
</tbody>
</table>

**Fax the COMPLETED form OR call the plan with the requested information.**

### Patient Information

- **Date of Request for Authorization:** ________________
- **Patient/Member Name:** ___________________________
- **DOB:** ________________
- **Address (Street, Apt.#):** ___________________________
- **City/State/Zip:** ___________________________
- **Phone:** ___________________________
- **Medicaid Number:** ___________________________
- **MCO ID Number:** ___________________________

### Pregnancy Information and History

- **G T P A L:** (Note: A= abortion (spontaneous and medically induced) EDC ________________
- **Last menstrual period:** ________________
- **EDD:** ________________
- **Current Gestational age:** ________________ weeks

### Bed Rest

- **Yes**
- **No**

### Experiencing Preterm Labor

- **Yes**
- **No**

### Singleton Pregnancy

- **Yes**
- **No**

### Multiple Pregnancy

- **Yes**
- **No**

### Major Fetal or Uterine Anomaly

- **Yes**
- **No**

### Medication Allergies

- **No known drug allergies**

### Other Pertinent Clinical Information:

- ___________________________

### Pharmacy Information

- **Ship to patient's home address:** ________________
- **End Date of Service:** ________________
- **Ship to provider's address:** ________________
- **End Date of Service:** ________________

### Provider Information

- **Ordering Provider Name:** ___________________________
- **Ordering Provider NPI:** ___________________________
- **Tax ID:** ___________________________
- **Address:** ___________________________
- **City/State/Zip:** ___________________________
- **Phone:** ___________________________
- **Fax:** ___________________________

### Practice Information

- **Practice Name:** ___________________________
- **Practice NPI:** ___________________________
- **Contact Person:** ___________________________
- **Phone:** ___________________________
- **Fax:** ___________________________

### MCO Use Only

- **Approved:** ________________
- **Denied Authorization #:** ________________
- **Number of Injections:** ________________
- **Date of Notification to Provider:** ________________
- **Reviewer(s) name & title:** ___________________________

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

**Prescription may be written prior to 16 weeks, but the vial shipment may be withheld by the pharmacy until the 15th week.**