Claims Filing Instructions
# Table of Contents

- **PROCEDURES FOR CLAIM SUBMISSION** .......................................................... 4
- **CLAIMS FILING DEADLINES** ........................................................................ 4
- **CLAIM REQUESTS FOR RECONSIDERATION, CLAIM DISPUTES AND CORRECTED CLAIMS** ............................................. 5
- **PROCEDURES FOR ELECTRONIC SUBMISSION** ............................................. 6
- **FILING CLAIMS ELECTRONICALLY** .............................................................. 6
- **HOW TO START** .......................................................................................... 6
- **SPECIFIC DATA RECORD REQUIREMENTS** ................................................ 6
- **ELECTRONIC CLAIM FLOW DESCRIPTION & IMPORTANT GENERAL INFORMATION** ............................................................. 6
- **INVALID ELECTRONIC CLAIM RECORD REJECTIONS/DENIALS** .......... 7
- **EXCLUSIONS** ............................................................................................... 7
- **ELECTRONIC BILLING INQUIRIES** ................................................................ 7
- **IMPORTANT STEPS TO A SUCCESSFUL SUBMISSION OF EDI CLAIMS** ........ 8
- **EFT AND ERA** ............................................................................................ 8
- **PROCEDURES FOR ONLINE CLAIM SUBMISSION** ........................................ 8
- **CLAIM FORM REQUIREMENTS** .................................................................. 9
- **CLAIM FORMS** .......................................................................................... 9
- **CODING OF CLAIMS** .................................................................................. 9
- **CODE AUDITING AND EDITING** ................................................................ 9
- **CPT® CATEGORY II CODES** ......................................................................... 12
- **CODE EDITING ASSISTANT** ....................................................................... 12
- **BILLING CODES** ........................................................................................ 13
- **CLAIMS MAILING INSTRUCTIONS** .............................................................. 13
- **REJECTIONS VS. DENIALS** ......................................................................... 14
- **COMMON CAUSES OF UPFRONT REJECTIONS** .......................................... 14
- **COMMON CAUSES OF CLAIM PROCESSING DELAYS AND DENIALS** .... 14
- **IMPORTANT STEPS TO A SUCCESSFUL SUBMISSION OF PAPER CLAIMS** ............................................................. 14
- **RESUBMITTED CLAIMS** .............................................................................. 15
- **APPENDIX** .................................................................................................. 16
- **APPENDIX I: COMMON REJECTIONS FOR PAPER CLAIMS** ..................... 16
- **APPENDIX II: COMMON CAUSES OF PAPER CLAIM PROCESSING DELAYS OR DENIALS** ............................................................. 16
- **APPENDIX III: EOP DENIAL CODES AND DESCRIPTIONS** ....................... 17
- **APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION** ........ 19
- **CMS-1500 (8/05) FORM, SHADED FIELD 24A-G** ....................................... 19
- **APPENDIX V: HIPAA COMPLIANT EDI REJECTION CODES** ...................... 20
- **APPENDIX VI: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION** .... 21
Procedures for Claim Submission

CountyCare Health Plan is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. Claims will be rejected or denied if not submitted correctly. In general, CountyCare Health Plan follows the CMS (Centers for Medicare & Medicaid Services) billing requirements. For questions regarding billing requirements, contact a CountyCare Health Plan Provider Services representative at 312-864-8200 or toll free 855-444-1661.

When required data elements are missing or are invalid, claims will be rejected or denied by CountyCare Health Plan for correction and re-submission.

- Rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP).

Claims for billable services provided to CountyCare Health Plan members must be submitted by the provider who performed the services or by the provider’s authorized billing vendor.

All claims filed with CountyCare Health Plan are subject to verification procedures. These include but are not limited to verification of the following:

- All required fields are completed on an original CMS 1500, UB-04 paper claim form, or EDI electronic claim format.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service.
- All Diagnosis, Procedure, Modifier, and Location (Place of Service) Codes are valid for provider type/specialty billing.
- All Diagnosis, Procedure, and Revenue Codes are valid for the age and/or sex for the date of the service billed.
- All Diagnosis Codes are to their highest number of digits available (4th or 5th digit).

- Principle Diagnosis billed reflects an allowed Principle Diagnosis as defined in the volume of ICD-9 CM or ICD-9 CM update for the date of service billed.
- Member is eligible for services under CountyCare Health Plan during the time period in which services were provided.
- Services were provided by a participating provider or if provided by an “out of network” provider, authorization has been received to provide services to the eligible member (excludes services by an “out of network” provider for an emergency medical condition; however authorization requirements apply for post-stabilization services).
- An authorization has been given for services that require prior authorization by CountyCare Health Plan.
- Medicare coverage or other third party coverage.

CLAIMS FILING DEADLINES

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

All corrected claims, requests for reconsideration or claim disputes must be received within 365 calendar days from the date of notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 365 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider’s business office or records by a natural disaster.
- Mechanical or administrative delays or errors by CountyCare Health Plan or the Illinois Department of Health and Family Services (HFS).
CLAIM REQUESTS FOR RECONSIDERATION, CLAIM DISPUTES AND CORRECTED CLAIMS

All claim requests for reconsideration, corrected claims or claim disputes must be received within 365 calendar days from the date of notification of payment or denial is issued.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are four (4) effective ways in which the provider can contact CountyCare Health Plan.

1. Contact a CountyCare Health Plan Provider Service Representative at 312-864-8200 or toll free 855-444-1661
   ■ Providers may discuss questions with CountyCare Health Plan Provider Services Representatives regarding amount reimbursed or denial of a particular service.

2. Submit an Adjusted or Corrected Claim to CountyCare Health Plan, Attn: Corrected Claim, PO Box 5020, Farmington MO 63640-5020
   ■ Resubmissions should be typed or printed on a red and white claim form and must include the original claim number in field 22 of a CMS 1500 (02/12) or field 64 of a CMS 1450 (UB-04) and the original EOP must be included with the resubmission.
   ■ Failure to resubmit on a red and white claim form and include the original claim number and include the EOP may result in the claim being denied as a duplicate, a delay in the reprocessing, or denied for exceeding the timely filing limit.

3. Submit a “Request for Reconsideration” to CountyCare Health Plan, Attn: Reconsideration, PO Box 5020, Farmington MO 63640-5020
   ■ A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
   ■ The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name.
   ■ The documentation must also include a detailed description of the reason for the request.

4. Submit a “Claim Dispute Form” to CountyCare Health Plan, Attn: Dispute, PO Box 5020, Farmington MO 63640-5020
   ■ A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
   ■ The Claim Dispute Form can be located on the provider website at www.countycare.com.

If the Provider Service contact, the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

CountyCare Health Plan shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 365 business days of receipt of the corrected claim, request for reconsideration or claim dispute.

CLAIM PAYMENT

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:
■ 90% of clean claims will be processed within 30 business days of receipt
■ 99% of clean claims will be processed within 90 business days of receipt

Adjusted claims, requests for reconsideration and disputed claims will be finalized to a paid or denied status 45 business days of receipt.
Procedures for Electronic Submission

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

The benefits of billing electronically include:

▪ Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).

▪ Receipt of clearinghouse reports as proof of claim receipt. This makes it easier to track the status of claims.

▪ Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.

▪ Validation of data elements on the claim format. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.

▪ Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing. Claims that are not submitted correctly or containing the allowed field data will be rejected and/or denied.

FILING CLAIMS ELECTRONICALLY

How to Start

▪ First, the provider will need specific hardware/software requirements. There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims, whether through direct submission to the clearinghouse or through another clearinghouse, you can submit claims electronically.

▪ Second, the provider needs to contact their clearinghouse and confirm they will transmit the claims to one of the clearinghouses used by CountyCare Health Plan. For a list of vendors used by CountyCare Health Plan, please visit our website at www.countycare.com. Go to the Provider page and click on Resources.

▪ Third, the provider should confirm with their clearinghouse the accurate location of the CountyCare Health Plan Payer ID number.

▪ Last, the provider needs to verify with CountyCare Health Plan that their provider record is set up within the claim adjudication system.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com. At times, a voicemail will have to be left on the EDI line. You will receive a return call within 24 business hours.

The companion guides and clearinghouse options are on the CountyCare Health Plan website at www.countycare.com.

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

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. The companion guide is located on CountyCare Health Plan website at www.countycare.com.

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to CountyCare Health Plan, all EDI claims must first be forwarded to one of CountyCare Health Plan’s clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to CountyCare Health Plan. The name of this report can vary based upon the provider’s contract with their intermediate EDI clearinghouse. Accepted claims are passed to CountyCare Health Plan, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to CountyCare Health Plan by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims and these claims need to be reviewed and corrected timely. Claims passing eligibility
requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgments for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

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

- If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

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

**Invalid Electronic Claim Record Rejections/Denials**
All claim records sent to CountyCare Health Plan must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by CountyCare Health Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Our companion guides to billing electronically are available on our website at www.countycare.com. See section on electronic claim filing for more details.

**Electronic Billing Inquiries**
Please direct inquiries as follows:

<table>
<thead>
<tr>
<th>ACTION</th>
<th>CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you would like to transmit claims electronically...</td>
<td>Contact one of the clearinghouses for CountyCare Health Plan’s</td>
</tr>
<tr>
<td>If you have a general EDI question...</td>
<td>Contact EDI Support at 800-225-2573 Ext.25525 or via e-mail at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a>.</td>
</tr>
<tr>
<td>If you have questions about specific claims transmissions or acceptance Claim Status reports...</td>
<td>Contact your clearinghouse technical support area</td>
</tr>
<tr>
<td>If you have questions about your Claim Status (if claim has been accepted or rejected by the clearinghouse)...</td>
<td>Contact EDI Support at 800-225-2573 Ext.25525 or via e-mail at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a>.</td>
</tr>
<tr>
<td>If you have questions about claims that are reported on the Remittance Advice...</td>
<td>Contact Provider Services at 312-864-8200 or toll free 855-444-1661</td>
</tr>
<tr>
<td>If you would like to update provider, payee, UPIN, Tax ID number or payment address information...</td>
<td>Notify Provider Services in writing at: CountyCare Health Plan 77 W. Wacker Drive, Chicago, IL 60601</td>
</tr>
<tr>
<td>For questions about changing or verifying provider information...</td>
<td>Attn: Provider Services 77 W. Wacker Drive, Chicago, IL 60601 Telephone: 312-864-8200 or toll free 855-444-1661 Or By Fax: 855-254-1791</td>
</tr>
</tbody>
</table>

**Exclusions**
Certain claims are excluded from electronic billing.

- **Excluded Claim Categories** – At this time, these claim records must be submitted on paper.

These exclusions apply to inpatient and outpatient claim types.

**Excluded Claim Categories**
- Claim records requiring supportive documentation or attachments. Note: COB claims can be filed electronically, but if they are not, the primary payer EOB must be submitted with the paper claim.
- Claim records billing with miscellaneous codes
- Claim records for medical, administrative or claim reconsideration or dispute requests
- Claim requiring documentation of the receipt of an informed consent form
- Claim for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics). Provider is required to submit the invoice with the claim.
- Claim for services requiring clinical review (e.g. complicated or unusual procedure). Provider is required to submit medical records with the claim.
- Claim for services needing documentation and requiring Certificate of Medical Necessity - oxygen, motorized wheelchairs

**NOTE:** Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the provider number fields are empty.
**Important Steps to a Successful Submission of EDI Claims**

1. Select clearinghouse to utilize.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to CountyCare Health Plan.
3. Inquire with the clearinghouse what data records are required.
4. Verify with Provider Relations at CountyCare Health Plan that the provider is set up in the CountyCare Health Plan system before submitting EDI claims.
5. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to CountyCare Health Plan and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by CountyCare Health Plan. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted correct and resubmit.
6. MOST importantly, all claims must be submitted with providers identifying numbers. See the CMS 1500 (2/12) and UB-04 UB1450 claim form instructions and claim forms for details.

**EFT and ERA**

CountyCare Health Plan has partnered with PaySpan to provide an innovative web-based solution for Electronic Funds Transfers (EFT’s) and Electronic Remittance Advices (ERA’s). Through this free service, providers can take advantage of EFTs and ERAs to settle claims electronically. For more information, please visit our provider home page on our website at www.countycare.com or to sign up for this quick and efficient service you may go directly to www.payspan.com.

For participating providers who have internet access and choose not to submit claims via EDI, CountyCare Health Plan has made it easy and convenient to submit claims directly to us on our website at www.countycare.com.

**Procedures for Online Claim Submission**

You must request access to our secure site by registering for a user name and password and have requested claims access. To obtain an ID, please contact Provider Relations at 1-312-864-8200 or toll free 1-855-444-1661. Requests are processed within two (2) business days.

Once you have access to the secure portal you may view web claims, allowing you to re-open and continue working on saved, un-submitted claims and this feature allows you to track the status of claims submitted using the website.
The code editing software contains a comprehensive set of rules, addressing coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- **American Medical Association (AMA)** – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider’s View, the AMA web site, and other sources.
- **Centers for Medicare & Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI)** which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA’s CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- **Public-domain specialty society guidance** (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- **Clinical consultants** who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

The following provides conditions where the software will make a change on submitted codes:

**Unbundling of Services** – identifies procedures that have been unbundled.

**Example:** Unbundling lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>80053</td>
<td>Comprehensive Metabolic Panel</td>
<td>Disallow</td>
</tr>
<tr>
<td>85025</td>
<td>Complete CBC, automated and automated differential and WBC count</td>
<td>Disallow</td>
</tr>
<tr>
<td>84443</td>
<td>Thyroid Stimulating Hormone</td>
<td>Disallow</td>
</tr>
<tr>
<td>80050</td>
<td>General Health Panel</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:** 80053, 85025 and 84443 are included in the lab
panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>80053</td>
<td>Comprehensive Metabolic Panel</td>
<td>Disallow</td>
</tr>
<tr>
<td>85025</td>
<td>Complete CBC, automated and automated &amp; automated differential WBC count</td>
<td>Disallow</td>
</tr>
<tr>
<td>84443</td>
<td>Thyroid Stimulating Hormone</td>
<td>Disallow</td>
</tr>
<tr>
<td>80050</td>
<td>General Health Panel</td>
<td>Add</td>
</tr>
</tbody>
</table>

**Explanation:** 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and CPT code 80050 is added to a new service line and recommended for reimbursement.

**Bilateral Surgery** – bilateral surgeries are identical procedures performed on bilateral anatomical sites during the same operative session.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>69436</td>
<td>Tympanostomy</td>
<td>Disallow</td>
</tr>
<tr>
<td>69436 50</td>
<td>Tympanostomy billed with modifier 50 (bilateral procedure)</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:** identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure). Note: Modifiers RT (right), or LT (left) should not be billed for bilateral procedures.

**Duplicate services** – submission of the same procedure more than once on the same date for services that cannot be or are normally not performed more than once on the same date.

**Example:** excluding a duplicate CPT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey study, anteroposterior &amp; lateral</td>
<td>Allow</td>
</tr>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey study, anteroposterior &amp; lateral</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**Explanation:**

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.
- It is clinically unlikely that this procedure would be performed twice on the same date of service.

**Evaluation and Management Services** – submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.

**GLOBAL SURGERY**

Procedures that are assigned a 90-day global surgery period are designated as major surgical procedures; those assigned a 10-day or 0-day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service unless the service is a service listed on the Illinois Fee Schedule with an asterisk.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>Allow</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling &amp; coordination of care w/other providers or agencies are provided consistent w/ nature of problem(s) &amp; patient’s &amp;/or family’s needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/patient &amp;/or family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>
**Explanation:**
- Procedure code 27447 has a global surgery period of 90 days.
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

**Example:**
- Example: evaluation and management service submitted with minor surgical procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>11000</td>
<td>DOS=01/23/10 Debridement of extensive eczematous or infected skin; up to 10% of body surface.</td>
<td>Allow</td>
</tr>
<tr>
<td>99213</td>
<td>DOS=01/23/10 Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient’s and/or family’s needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face with patient and/or family.</td>
<td>Disallow</td>
</tr>
<tr>
<td>99242</td>
<td>DOS=01/23/10 Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient’s/family’s needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face-to-face with patient/family.</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.
NOTE:

**MODIFIER – 24** is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

**MODIFIER – 25** is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

**MODIFIER – 79** is used to report an unrelated procedure or service by the same physician during the post-operative period.

When **MODIFIERS – 24 AND – 25** are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

When **MODIFIER – 79** is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.

**MODIFIERS** – Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance.

**MODIFIER – 26** (professional component)

**Definition:** Modifier - 26 identifies the professional component of a test or study.

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier - 26 appended.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>78278</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Disallow</td>
</tr>
<tr>
<td>78278-26</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:**

- Procedure code 78278 is valid with modifier -26.
- Modifier -26 will be added to procedure code 78278 when submitted without modifier - 26.

**MODIFIER – 80, –81, –82, and -AS (assistant surgeon)**

**Definition:** This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>42820-81</td>
<td>Tonsillectomy and adenoidectomy; under age 12</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**Explanation:**

- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance this procedure.

**CPT® CATEGORY II CODES**

CPT Category II Codes are supplemental codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service, thus reducing the need for retrospective medical record review.

Use of these codes is optional and are not required for correct coding and may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

**CODE EDITING ASSISTANT**

A web-based code auditing reference tool designed to “mirror” how CountyCare Health Plan code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers. This allows CountyCare Health Plan to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted
- Proactively determine the appropriate code/code combination representing the service for accurate billing purposes
The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a ‘what if’ or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements or other coverage considerations.

**BILLING CODES**

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-9 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-9 codes and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a member’s diagnosis. We require the use of valid ICD-9 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-9 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-9 manual (Note: not all codes require a fourth or fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-9 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes. The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to the fifth digit, if appropriate. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC, and V72.85 for Other Specified Exam as the principal diagnosis on the claim. Please consult your ICD-9 manual for further instruction. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC, and V72.85 for Other Specified Exam as the principal diagnosis on the claim.

In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of CountyCare Health Plan.

**Claims Mailing Instructions**

Submit claims to CountyCare Health Plan at the following address:

**First Time Claims, Corrected Claims and Requests for Reconsiderations:**

CountyCare Health Plan, Inc. Claim Processing Department
P. O. Box 5020
Farmington, MO 63640-5020

Claim Disputes must be submitted to:

CountyCare Health Plan
Attn: Claim Disputes
P. O. Box 5020
Farmington, MO 63640-5020

Please do not use any other post office box that you may have for CountyCare Health Plan as it may cause a delay in processing. CountyCare Health Plan encourages all providers to submit claims electronically. Our companion guides to billing electronically are available on our website at www.countycare.com. See section on electronic claim filing for more details. You may also submit claims on-line using our secure website at www.countycare.com.

**Claim Form Instructions**

Our companion guides to billing are available on our website at www.countycare.com.
Rejections Vs. Denials

All paper claims sent to the Claims Office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

A REJECTION is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.countycare.com. A list of common upfront rejections can be found listed below and a more comprehensive list with explanations can be located in Appendix 1.

If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed minimum edits and is entered into the system, however has been billed with invalid or inappropriate information causing the claim to deny. An EOP (Explanation of Payment) will be sent that includes the denial reason. A list of common delays and denials can be found listed below and a more comprehensive list with explanations can be located in Appendix 2.

COMMON CAUSES OF UPFRONT REJECTIONS

- Unreadable Information – Information within the claim form cannot be read. The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or information is hand written or submitted on a black and white claim form.
- Member DOB (date of birth) is missing.
- Member Name or identification (ID) number is missing or invalid
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) number is missing.
- DOS – The DOS (date of service) on the claim is not prior to receipt of claim (future date of service).
- DATES – A date or dates are missing from required fields. Example: “Statement From” UB-04 & Service From” 1500 (02/12). “To Date” before “From Date”.
- TOB – Invalid TOB (Type of Bill) entered.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail – No service line detail submitted.
- DOS (date of service) entered is prior to the member’s effective date.
- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14)
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17).
- Occurrence Code/Date is missing or invalid.
- RE Code (revenue code) is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- Incorrect Form Type – The form is not a form accepted by CountyCare Health Plan or not allowed for the provider type.
- CLIA – Missing/incomplete/invalid CLIA certification number
- Wrong Form Type – The paper claim form submitted is not on a “red” dropout OCR form.
- Procedure or Modifier Codes entered are invalid or missing.
- Revenue Code is invalid.

COMMON CAUSES OF CLAIM PROCESSING DELAYS AND DENIALS

- Diagnosis Code is missing the 4th or 5th digit.
- DRG code is missing or invalid.
- EOB (Explanation of Benefits) from the Primary insurer is missing or incomplete.
- Place of Service Code is invalid.
- Provider TIN and NPI does not match.
- Dates of Service span do not match the listed Days/Units.
- Physician Signature is missing.
- Tax Identification Number (TIN) is invalid.
- Third Party Liability (TPL) information is missing or incomplete.

IMPORTANT STEPS TO A SUCCESSFUL SUBMISSION OF PAPER CLAIMS

1. Complete all required fields on an original, red CMS 1500 (02/12) or UB-04 form.
2. Ensure all Diagnosis, Procedure, Modifier, Location (Place of Service), Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
3. Ensure all diagnosis and procedure codes are appropriate for the age and sex of the member.
4. Complete the ICD code type on both HCFA (box 21 upper right corner and UB-04 box 66) with a 9 for ICD9 and 0 for ICD10.
5. Ensure all diagnosis codes are coded to their highest number of digits available (fourth and fifth digit).
6. Ensure member is eligible for services under CountyCare Health Plan during the time period in which services were provided.
7. Ensure an authorization has been given for services that require prior authorization by CountyCare Health Plan.
8. Ensure claims are submitted on an original red and white form. Handwritten and black and white claim forms will be rejected and returned to the provider.
RESUBMITTED CLAIMS
All requests for reconsideration, claim disputes or corrected claims must be received within 365 calendar days from the date of notification of payment or denial.

Resubmissions should be typed or printed on a red and white claim form and must include the original claim number in field 22 of a CMS 1500 (02/12) or field 64 of a CMS 1450 (UB-04). The original EOP must also be included with the resubmission. Failure to do this could result in a claim denying as a duplicate, a delay in processing, or denied for exceeding the timely filing limit.
Appendix

I. Common Rejections for Paper Claims
II. Common Causes of Paper Claim Processing Denial
III. EOP Denial Codes
IV. Instructions for Supplemental Information CMS-1500 (02/12) Form, Shaded Field 24a-G
V. HIPAA Compliant EDI Rejection Codes

APPENDIX I:
COMMON REJECTIONS FOR PAPER CLAIMS

- Member DOB missing from the claim.
- Member Name or Id Number missing or invalid from the claim.
- Provider Name, TIN, or NPI Number missing from claim.
- Claim data is unreadable due to either too light (insufficient toner), dot-matrix printers, or too small font to allow for clear electronic imaging of claim. All black and handwritten claims will be rejected back to the provider.
- Diagnosis Code missing or invalid.
- REV Code missing or invalid.
- CPT/Procedure Code missing or invalid.
- Dates missing from required fields. Example: “Statement From” UB-04 & “Service From” 1500 (02/12). “To Date” before “From Date.”
- DOS on claim is not prior to receipt of claim (future date of services).
- DOS prior to effective date of Health Plan or prior to member eligibility date.
- Incorrect Form Type Used (approved form types are CMS 1500 (02/12) for professional medical services or the UB-04 for all facility claims).
- Invalid TOB or invalid type of bill.
- No detail service line submitted.
- Admission Type missing (when Inpatient Facility Claim only).
- Patient Status missing (when Inpatient Facility Claim only).
- CLIA certification missing/invalid or incomplete.
- Procedure or Modifier Codes Invalid or Missing – Coding from the most current coding manuals (CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.
- Revenue Codes Missing or Invalid – Facility claims must include a valid three or four-digit numeric revenue code. Refer to UB-92 coding manual for a complete list of revenue codes.

APPENDIX II:
COMMON CAUSES OF PAPER CLAIM PROCESSING DELAYS OR DENIALS

- Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form.
- Diagnosis Code Missing 4th or 5th Digit – Diagnosis should be billed to the highest intensity for proper coding and processing. Review the ICD-9-CM manual for coding to the 4th and 5th digit.
- DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG (Diagnosis Related Grouping) codes should include this information on the claim form for accurate payment. Invalid DRG codes will result in denial.
- Primary Insurers EOB (Explanation of Benefits) is Missing or Incomplete – Claims for Members who have OIC (other insurance carrier) must be billed along with a copy of the primary EOB from the OIC (either paid or denied). Include pages with run dates, coding explanations, and messages.
- Place of Service Code 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 TIN and NPI Do Not Match – The submitted NPI does not match Provider’s Tax ID number on file.
- Date Span Billed does not match Days/Units Billed – Spanned dates of service can only be billed for consecutive days along with matching number of days/units (i.e. Date Span of 01/01 to 01/03 and days/units = 3).
- Signature Missing – The signature of the provider of service, or an authorized representative must be present on the claim form
- Tax Identification Number (TIN) Missing or Invalid – Provider’s Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with CountyCare Health Plan.
<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>07</td>
<td>DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT’S SEX</td>
</tr>
<tr>
<td>09</td>
<td>DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT’S SEX</td>
</tr>
<tr>
<td>10</td>
<td>DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT’S AGE</td>
</tr>
<tr>
<td>16</td>
<td>DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED</td>
</tr>
<tr>
<td>18</td>
<td>DENY: DUPLICATE CLAIM/SERVICE</td>
</tr>
<tr>
<td>1K</td>
<td>DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT</td>
</tr>
<tr>
<td>1L</td>
<td>DENY: VISIT &amp; PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION</td>
</tr>
<tr>
<td>20</td>
<td>DENY: THIS INJURY IS COVERED BY THE LIABILITY CARRIER</td>
</tr>
<tr>
<td>21</td>
<td>DENY: CLAIM THE RESPONSIBILITY OF THE NO-FAULT CARRIER</td>
</tr>
<tr>
<td>22</td>
<td>DENY: THIS CARE IS COVERED BY A COORDINATION OF BENEFITS CARRIER</td>
</tr>
<tr>
<td>23</td>
<td>DENY: CHARGES HAVE BEEN PAID BY ANOTHER PARTY-COB</td>
</tr>
<tr>
<td>24</td>
<td>DENY: CHARGES COVERED UNDER CAPITATION</td>
</tr>
<tr>
<td>25</td>
<td>DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET</td>
</tr>
<tr>
<td>26</td>
<td>DENY: EXPENSES INCURRED PRIOR TO COVERAGE</td>
</tr>
<tr>
<td>27</td>
<td>DENY: EXPENSES INCURRED AFTER COVERAGE WAS TERMINATED</td>
</tr>
<tr>
<td>28</td>
<td>DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED</td>
</tr>
<tr>
<td>29</td>
<td>DENY: THE TIME LIMIT FOR FILING HAS EXPIRED</td>
</tr>
<tr>
<td>35</td>
<td>DENY: BENEFIT MAXIMUM HAS BEEN REACHED</td>
</tr>
<tr>
<td>3D</td>
<td>DENY: NON-SPECIFIC DIAGNOSIS - REQUIRES 4TH DIGIT PLEASE RESUBMIT</td>
</tr>
<tr>
<td>46</td>
<td>DENY: THIS SERVICE IS NOT COVERED</td>
</tr>
<tr>
<td>48</td>
<td>DENY: THIS PROCEDURE IS NOT COVERED</td>
</tr>
<tr>
<td>4D</td>
<td>DENY: NON-SPECIFIC DIAGNOSIS - REQUIRES 5TH DIGIT PLEASE RESUBMIT</td>
</tr>
<tr>
<td>6L</td>
<td>EOB INCOMPLETE - PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL</td>
</tr>
<tr>
<td>86</td>
<td>DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE</td>
</tr>
<tr>
<td>99</td>
<td>DENY: MISCELLANEOUS CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT</td>
</tr>
<tr>
<td>9I</td>
<td>INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED</td>
</tr>
<tr>
<td>A1</td>
<td>DENY: AUTHORIZATION NOT ON FILE</td>
</tr>
<tr>
<td>BG</td>
<td>DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT</td>
</tr>
<tr>
<td>BI</td>
<td>DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL</td>
</tr>
<tr>
<td>C2</td>
<td>CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>C6</td>
<td>CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>C8</td>
<td>CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>CV</td>
<td>DENY: BILL WITH SPECIFIC VACCINE CODE</td>
</tr>
<tr>
<td>DD</td>
<td>DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED</td>
</tr>
<tr>
<td>DJ</td>
<td>DENY: INAPPROPRIATE CODE BILLED, CORRECT &amp; RESUBMIT</td>
</tr>
<tr>
<td>DS</td>
<td>DENY: DUPLICATE SUBMISSION - ORIGINAL CLAIM STILL IN PEND STATUS</td>
</tr>
<tr>
<td>DT</td>
<td>DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING</td>
</tr>
<tr>
<td>DW</td>
<td>DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT</td>
</tr>
<tr>
<td>DX</td>
<td>DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE</td>
</tr>
<tr>
<td>DY</td>
<td>DENY: APPEAL DENIED</td>
</tr>
<tr>
<td>DZ</td>
<td>DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT</td>
</tr>
<tr>
<td>EB</td>
<td>DENY: DENIED BY MEDICAL SERVICES</td>
</tr>
<tr>
<td>EC</td>
<td>DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>FP</td>
<td>DENY: CLAIMS DENIED FOR PROVIDER FRAUD</td>
</tr>
<tr>
<td>FQ</td>
<td>DENY: RESUBMIT CLAIM UNDER FQHC/RHC CLINIC MEDICAID NUMBER</td>
</tr>
<tr>
<td>GL</td>
<td>SERVICE COVERED UNDER GLOBAL FEE AGREEMENT</td>
</tr>
<tr>
<td>GM</td>
<td>DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K</td>
</tr>
<tr>
<td>HI</td>
<td>DENY: PROVIDER MUST USE HCPC/CPT FOR CORRECT PRICING</td>
</tr>
<tr>
<td>HL</td>
<td>DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH</td>
</tr>
<tr>
<td>HP</td>
<td>DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING</td>
</tr>
<tr>
<td>HQ</td>
<td>DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED</td>
</tr>
<tr>
<td>HS</td>
<td>DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING</td>
</tr>
<tr>
<td>Denial Code</td>
<td>Denial Description</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>HT</td>
<td>DENY: CLAIM AND AUTH Treatment Type NOT MATCHING</td>
</tr>
<tr>
<td>II</td>
<td>OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>I9</td>
<td>DENY: DIAGNOSIS IS AN INVALID OR DELETED ICD9 CODE</td>
</tr>
<tr>
<td>IE</td>
<td>CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE</td>
</tr>
<tr>
<td>IK</td>
<td>DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 &amp; MED RECORDS, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>IL</td>
<td>VERIFY THE CORRECT LOCATION CODE FOR SERVICE BILLED AND RESUBMIT</td>
</tr>
<tr>
<td>IM</td>
<td>DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT</td>
</tr>
<tr>
<td>IV</td>
<td>DENY: INVALID/DELETED/MISSING CPT CODE</td>
</tr>
<tr>
<td>L0</td>
<td>PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS</td>
</tr>
<tr>
<td>L6</td>
<td>DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.</td>
</tr>
<tr>
<td>LO</td>
<td>DENY: CPT &amp; LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>MS</td>
<td>DENY: IMMUNIZATION ADMINISTRATION INCLUDED IN INJECTION FEE</td>
</tr>
<tr>
<td>MA</td>
<td>MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT</td>
</tr>
<tr>
<td>MG</td>
<td>DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>MH</td>
<td>DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING</td>
</tr>
<tr>
<td>MO</td>
<td>MODIFIER BILLED IS NOT VALID, PLEASE SUBMIT WITH CORRECT CODE.</td>
</tr>
<tr>
<td>MQ</td>
<td>DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>MY</td>
<td>DENY: MEMBER'S PCP IS CAPITATED - SERVICE NOT REIMBURSABLE TO OTHER PCPS</td>
</tr>
<tr>
<td>NS</td>
<td>DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM</td>
</tr>
<tr>
<td>ND</td>
<td>DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE</td>
</tr>
<tr>
<td>NT</td>
<td>DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT</td>
</tr>
<tr>
<td>NV</td>
<td>DENY: STERILIZATION CONSENT FORM IS NOT VALID OR IS MISSING INFORMATION</td>
</tr>
<tr>
<td>NX</td>
<td>DENY: INVALID OR NO TAX ID NUMBER SUBMITTED ON CLAIM, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>OX</td>
<td>DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED</td>
</tr>
<tr>
<td>PF</td>
<td>DENY: PROFESSIONAL FEE MUST BE BILLED ON HCFA FORM</td>
</tr>
<tr>
<td>RC</td>
<td>DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING</td>
</tr>
<tr>
<td>RD</td>
<td>DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>RX</td>
<td>DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING.</td>
</tr>
<tr>
<td>TM</td>
<td>TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>U1</td>
<td>CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS</td>
</tr>
<tr>
<td>U5</td>
<td>DENY: UNLISTED / UNSPECIFIC CODE - RE-BILL MORE SPECIFIC CODE</td>
</tr>
<tr>
<td>V3</td>
<td>MED RECORDS RECEIVED FOR WRONG DATE OF SERVICE</td>
</tr>
<tr>
<td>V4</td>
<td>MED RECORDS RECEIVED NOT LEGIBLE</td>
</tr>
<tr>
<td>V5</td>
<td>MED RECORDS RECEIVED FOR WRONG PATIENT</td>
</tr>
<tr>
<td>V6</td>
<td>MED RECORDS WITHOUT LEGIBLE PATIENT NAME AND/OR DOS</td>
</tr>
<tr>
<td>V8</td>
<td>MED RECORDS RECEIVED WITHOUT DOS</td>
</tr>
<tr>
<td>VC</td>
<td>DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES</td>
</tr>
<tr>
<td>VS</td>
<td>DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING.</td>
</tr>
<tr>
<td>x3</td>
<td>PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE</td>
</tr>
<tr>
<td>x4</td>
<td>PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBERS GENDER</td>
</tr>
<tr>
<td>x5</td>
<td>PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE</td>
</tr>
<tr>
<td>x6</td>
<td>ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE</td>
</tr>
<tr>
<td>x7</td>
<td>ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE</td>
</tr>
<tr>
<td>x8</td>
<td>MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED</td>
</tr>
<tr>
<td>x9</td>
<td>PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED</td>
</tr>
<tr>
<td>xa</td>
<td>CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE</td>
</tr>
<tr>
<td>xb</td>
<td>PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA</td>
</tr>
<tr>
<td>xc</td>
<td>PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID</td>
</tr>
<tr>
<td>xd</td>
<td>PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM</td>
</tr>
<tr>
<td>xe</td>
<td>PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE</td>
</tr>
<tr>
<td>xf</td>
<td>MAXIMUM ALLOWANCE EXCEEDED</td>
</tr>
<tr>
<td>xg</td>
<td>SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS</td>
</tr>
<tr>
<td>xh</td>
<td>SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED</td>
</tr>
<tr>
<td>ZC</td>
<td>DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY</td>
</tr>
</tbody>
</table>
APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION
CMS-1500 (02/12) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) form field 24A-G:

- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs
- Contract rate

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

CTR Contract rate
ZZ Narrative description of unspecified/miscellaneous/unlisted codes
N4 National Drug Codes (NDC)

The following qualifiers are to be used when reporting NDC units:

F2 International Unit
GR Gram
ME Milligram
ML Milliliter
UN Unit

if required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information

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

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

When reporting dollar amounts in the shaded area, always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not use commas. Do not enter dollar signs.

Examples: 1000.00, 123.45

Additional Information for Reporting NDC

When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas.

Examples: 1234.56
99999999.999

When a dollar amount is being reported, enter the following after the quantity: one space, dollar amount. Do not enter a dollar sign.

The following qualifiers are to be used when reporting NDC unit/basis of measurement:

F2 International Unit
ME Milligram UN Unit
GR Gram
ML Milliliter

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.
APPENDIX V: HIPAA COMPLIANT EDI REJECTION CODES

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Please see CountyCare Health Plan’s list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

1. Invalid Mbr DOB
2. Invalid Mbr
3. Invalid Prv
4. Invalid Mbr DOB & Prv
5. Invalid Mbr & Prv
6. Mbr not valid at DOS
7. Invalid Mbr DOB; Mbr not valid at DOS
8. Prv not valid at DOS
9. Invalid Mbr DOB; Prv not valid at DOS
10. Invalid Mbr; Prv not valid at DOS
11. Mbr not valid at DOS; Prv not valid at DOS
12. Invalid Mbr DOB; Prv not valid at DOS
13. Invalid Mbr; Prv not valid at DOS
14. Mbr not valid at DOS; Invalid Prv
15. Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
16. Invalid Diag
17. Invalid Mbr DOB; Invalid Diag
18. Invalid Mbr; Invalid Diag
19. Mbr not valid at DOS; Prv not valid at DOS
20. Invalid Mbr DOB; Mbr not valid at DOS
21. Prv not valid at DOS; Invalid Diag
22. Invalid Mbr DOB; Invalid Diag
23. Invalid Prv; Invalid Diag
24. Invalid Mbr DOB; Invalid Prv; Invalid Diag
25. Invalid Mbr; Invalid Prv; Invalid Diag
26. Mbr not valid at DOS; Invalid Diag
27. Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
28. Prv not valid at DOS; Invalid Diag
29. Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
30. Invalid Mbr; Prv not valid at DOS; Invalid Diag
31. Mbr not valid at DOS; Prv not valid; Invalid Diag
32. Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv;
33. Invalid Diag
34. Invalid Diag
35. Invalid Mbr DOB; Invalid Proc
36. Invalid Mbr; Invalid Proc
37. Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
38. Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
39. Invalid Mbr DOB; Invalid Prv; Invalid Proc
40. Invalid Prv; Invalid Proc
41. Invalid Mbr DOB, Invalid Prv; Invalid Proc
42. Invalid Mbr; Invalid Prv; Invalid Proc
43. Mbr not valid at DOS; Invalid Proc
APPENDIX VI: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION

Instructions for Entering the NDC:

CMS requires the 11-digit National Drug Code (NDC), therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which can be found on the vial of medication. The NDC must include the NDC Unit of Measure and NDC quantity/units.

When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug.

For Electronic submissions, which is highly recommended, and will enhance claim reporting/adjudication processes, report in the LIN segment of Loop ID-2410.

For Paper, use Form Locator 43 of the CMS1450 and the red shaded detail of 24A on the CMS1500 line detail. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer’s labeler code, the middle four digits are the product code, and the last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows:

For a 4-4-2 digit number, add a 0 to the beginning. For a 5-3-2 digit number, add a 0 as the sixth digit. For a 5-4-1 digit number, add a 0 as the tenth digit.

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:

- F2: International Unit
- GR: Gram
- ME: Milligram UN Unit
- ML: Milliliter
- UN: Unit