silversummit healthplan™

2026 Provider Billing Manual

PROVIDER SERVICES DEPARTMENT

1-844-366-2880 TTY: 711

SilverSummitHealthplan.com

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Contents

Introductory Billing Information

Billing Instructions

SilverSummit Healthplan follows CMS rules and regulations, specifically the Federal requirements set forth in 42 USC § 1396a (a) (37) (A), 42 CFR § 447.45 and 42 CFR § 447.46; and in accordance with State laws and regulations, as applicable.

General Billing Guidelines

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with SilverSummit Healthplan for payment of covered services.

It is important that providers ensure SilverSummit Healthplan has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Medicaid Number
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Providers must bill with their NPI number in box 24Jb. Providers must also bill their taxonomy code in box 24Ja and the Member's Medicaid number in box 1a on the CMS 1500, to avoid possible delays in processing. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

We recommend that providers notify SilverSummit Healthplan 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member must be effective on the date of service (see information below on identifying the enrollee.
- The service provided must be a covered benefit under the member's contract on the date of service, and prior authorization processes must be followed, if applicable.
- Payment for service is contingent upon compliance with prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

When submitting your claim, you need to identify the member. There are two ways to identify the member:

- The SilverSummit Healthplan member number found on the member ID card or the provider portal.
- The Medicaid Number provided by the State and found on the member ID card or the provider portal.

SilverSummit Healthplan only accepts the CMS 1500 (2/12) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (2/12) form and institutional providers complete the CMS 1450 (UB-04) claim form. SilverSummit Healthplan does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms are required to be typed or printed and in the original red and white version to ensure clean acceptance and processing. All claims with handwritten information or black and white forms will be rejected. If you have questions regarding what type of form to complete, contact SilverSummit Healthplan at the following phone number: 1-844-366-2880.

Billing Codes

SilverSummit Healthplan requires claims to be submitted using codes from the current version of, ICD-10, DSM, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service
- Code is inappropriate for the age or sex of the member
- Diagnosis code is missing digits.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of SilverSummit Healthplan.

CPT® Category II Codes

CPT Category II Codes are supplemental tracking 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 and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They 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.

Encounters vs Claim

You are required to submit an encounter or claim for each service that you render to a SilverSummit Healthplan member. See the definitions below:

If you are the PCP for a SilverSummit Healthplan member and receive a monthly capitation amount for services, you must file a "proxy claim" (also referred to as an "encounter") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the "proxy claim" or "encounter" is paid at zero-dollar amounts. It is mandatory that your office submits all encounter data. SilverSummit Healthplan utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by Centers for Medicare and Medicaid Services (CMS).

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a SilverSummit Healthplan member.

Clean Claim Definition

A clean claim means a claim received by SilverSummit Healthplan for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by SilverSummit Healthplan.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Rejection vs Denial

All claims sent to SilverSummit Healthplan 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.

REJECTION: An upfront 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. A list of common upfront rejections can be found on page 11. Upfront rejections will not enter our claims adjudication system, so there will not be an explanation of payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim is submitted electronically. If a claim is rejected, the identified issue must be corrected, and the claim resubmitted as an original claim.

DENIAL: If all 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 edits and is entered into the system, but that has been billed with invalid or inappropriate information that cause the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found below.

Claims Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90% within 30 calendar days of the date of receipt
- 99% within 90 calendar days of the date of receipt

Contact Information	
Plan Address / Administrative Office	SilverSummit Healthplan 2500 North Buffalo Drive, Suite 250 Las Vegas, NV 89128
Claims Submission Address	SilverSummit Healthplan Attn: Claims PO Box 5090 Farmington, MO 63640-5090
Customer Service	844-366-2880 TYY Users: 844-833-5780 Open Monday through Friday from 8:00 a.m. to 5:00 p.m.

Claims Payment Information

Systems Used to Pay Claims

SilverSummit Healthplan uses two main systems to process reimbursement on a claim. Those systems are:

- Amisys
- DST Pricer

AMISYS

All claims are processed from this system and structures are maintained to meet the needs of our provider contracts. However, we are not limited within the bounds of this one system. We utilize multiple systems to expand our universe of possibilities and better meet the needs of our business partners.

DST Pricer

The DST Pricer is a system outside our core system where we have some flexibility on addressing your contractual needs. It allows us to be more responsive to the market demands. It houses both Fee Schedules and procedure codes and mirrors our Amisys system, but with more attention to detail.

Electronic Claims Submission

Network providers are encouraged to participate in SilverSummit Healthplan's electronic claims/ encounter filing program. SilverSummit Healthplan can receive ANSI X12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). Providers that bill electronically have the same timely filing requirements as providers filing paper claims.

In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

SilverSummit Healthplan's Payor ID is 68069. Our Clearinghouse vendors include Change Healthcare (formerly Emdeon), Envoy, WebMD, Availity and TriZetto (formerly GatewayEDI). Please visit our website for our electronic Companion Guide which offers more instructions.

For questions or more information on electronic filing please contact:

SilverSummit Healthplan
c/o Centene EDI Department
1-800-225-2573, extension 6075525
Or by e-mail at EDIBA@centene.com

Paper Claim Submission

For SilverSummit Healthplan members, all claims and encounters should be submitted to:

SilverSummit Healthplan
Attn: Claims Department
PO Box 5090
Farmington, MO 63640-5090

Requirements

SilverSummit Healthplan uses an imaging process for paper claims retrieval. Please see Appendix 4 and 5 for required fields. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct P.O. Box number
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 10 to 12 point font
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do include the EOP from the primary insurance carrier when applicable
- Do submit on a proper original form - CMS 1500 or UB 04

Note: SilverSummit Healthplan is able to receive primary insurance carrier EOPs electronically.

Don'ts

- Don't submit handwritten claim forms
- Don't use red ink on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms (no black and white claim forms)
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax
- Don't utilize staples for attachments or multi page documents

Basic Guidelines for Completing the CMS-1500 Claim Form

(detailed instructions in appendix):

- Use one claim form for each recipient.
- Enter one procedure code and date of service per claim line.
- Enter information with a typewriter or a computer using black type.
- Enter information within the allotted spaces.
- Make sure whiteout is not used on the claim form.
- Complete the form using the specific procedure or billing code for the service.
- Use the same claim form for all services provided for the same recipient, same provider, and same date of service.
- If dates of service encompass more than one month, a separate billing form must be used for each month.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

SilverSummit Healthplan provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straight forward reconciliation of payments. As a Provider, you can gain the following benefits from using EFT and ERA:

1. Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
2. Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
3. Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
4. Match payments to ERAs quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information on our EFT and ERA services, please contact our Provider Services Department at:

SilverSummit Healthplan
2500 North Buffalo Drive, Suite 250
Las Vegas, NV 89128

Common Causes of Claims Processing Delays and Denials

- Incorrect Form Type
- Diagnosis Code Missing Digits
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid DRG Code
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete

- Invalid Member ID
- Invalid Place of Service Code
- Provider TIN and NPI Do Not Match
- Invalid Revenue Code
- Dates of Service Span Do Not Match Listed Days/Units
- Missing Physician Signature
- Invalid TIN
- Missing or Incomplete Third-Party Liability Information

SilverSummit Healthplan will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

Common Causes of Up-Front Rejections

- Unreadable Information
- Missing Member Date of Birth
- Missing Member Name or Identification Number
- Missing Provider Name, Tax ID, or NPI Number
- Missing Medicaid Number
- The Date of Service on the Claim is Not Prior to Receipt Date of the Claim
- Dates Are Missing from Required Fields
- Invalid or Missing Type of Bill
- Missing, Invalid or Incomplete Diagnosis Code
- Missing Service Line Detail
- Member Not Effective on The Date of Service
- Admission Type is Missing
- Missing Patient Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid CPT/Procedure Code
- Incorrect Form Type
- Claims submitted with handwritten data or black and white forms

SilverSummit Healthplan will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

CLIA Accreditation

Labs who participate in the Medicare or Medicaid sector with SilverSummit Healthplan must be CLIA accredited. Requirements for laboratory accreditation are contained in the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB) located at the following link: www.jcrinc.com/store/publications/manuals/

How to Submit a CLIA Claim Via Paper

Complete Box 23 of a CMS-1500 form with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

***Note** - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS-1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Via EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

***Note** - The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4. When the referring laboratory is the billing laboratory, the reference laboratory's name, NPI, address, and Zip Code shall be reported in loop 2310C. The 2420C loop is required if different then information provided in loop 2310C. The 2420C would contain Laboratory name and NPI.

Via AHA Provider Portal: Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

***Note** - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS-1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Third Party Liability / Coordination of Benefits

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member. Any other insurance, including Medicare, is always primary to Medicaid coverage.

SilverSummit Healthplan, like all Medicaid programs, is always the payer of last resort. Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to SilverSummit Healthplan members. If a member has other insurance that is primary, you must submit your claim to the primary insurance for consideration and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for a Member with insurance primary to Medicaid, the claim will pend and/or deny until this information is received. If a Member has another insurance carrier (Medicaid would be the third payer) and has an attachment, the claim should be submitted through the Health Plan secure web portal or via a paper claim.

If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources, the provider shall inform the health plan that efforts have been unsuccessful. SilverSummit Healthplan will make every effort to work with the provider to determine liability coverage.

If third-party liability coverage is determined after services are rendered, the health plan will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Billing the Member / Member Acknowledgement Statement

SilverSummit Healthplan reimburses only services that are medically necessary and covered through the program. Providers are not allowed to "balance bill" for covered services if the provider's usual and customary charge for covered services is greater than our fee schedule.

Providers may bill members for services NOT covered by either Medicaid or SilverSummit Healthplan or for applicable copayments, deductibles or coinsurance as defined by the State of Nevada.

In order for a provider to bill a member for services not covered under the program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgment prior to rendering the service, following this language (the Member Acknowledgement Statement):

I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Program as being reasonable and medically necessary for my care. I understand that SilverSummit Healthplan through its contract with the State Medicaid Agency determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Code Auditing and Editing

SilverSummit Healthplan uses HIPAA compliant clinical claims auditing software for physician and outpatient facility coding verification. The software will detect, correct, and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding "rule." When the software audits a claim that does not adhere to a coding rule, a recommendation known as an "edit" is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code auditing software is a useful tool to ensure provider compliance with correct coding, a fully automated code auditing software application will not wholly evaluate all clinical patient scenarios. Consequently, the health plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

Moreover, SilverSummit Healthplan may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

1. ***Level I HCPCS Codes (CPT):*** This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5-digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.

2. ***Level II HCPCS:*** The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics and prosthetics and etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.

3. ***Miscellaneous/Unlisted Codes:*** The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. ***Temporary National Codes:*** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

5. ***HCPCS Code Modifiers:*** Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10)

These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems.

Revenue Codes

These codes represent where a patient had services performed in a hospital or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims editing software application contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research and etc.

The software applies edits that are based on the following sources:

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits includes column 1/column 2, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments. Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- CMS Claims Processing Manual
- CMS Medicaid NCCI Policy Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources such as, HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals
- AMA resources
  - CPT Manual
  - AMA Website
  - Principles of CPT Coding

- Coding with Modifiers
- CPT Assistant
- CPT Insider's View
- CPT Assistant Archives
- CPT Procedural Code Definitions
- HCPCS Procedural Code Definitions

- Billing Guidelines Published by Specialty Provider Associations
  - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
  - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations

Code Auditing and the Claims Adjudication Cycle

Code auditing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code auditing cycle, each service line on the claim is processed through the code auditing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

Deny: Code auditing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.

Pend: Code auditing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions

Replace and Pay: Code auditing recommends the denial of a service line, and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Auditing Principles

The below principles do not represent an all-inclusive list of the available code auditing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

Unbundling:

CMS National Correct Coding Initiative- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS developed the correct coding initiative to control erroneous coding and prevent inaccurate claims payment. CMS NCCI edits consist of Procedure to Procedure (PTP) edits for physicians and hospitals and Medically Unlikely Edits for professionals and facilities.

PTP Practitioner and Hospital Edits

CMS has designated certain combinations of codes that should not be billed together. CMS developed the Procedure to Procedure (PTP), also known as Column I/Column II, edits to detect incorrect claims submitted by medical providers. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component of the column I code. While these codes should not typically be billed together, there are circumstances when an NCCI modifier may be appended to the column II code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed. PTP for practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). PTP hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Code Bundling Rules not sourced to CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public-domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

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

Evaluation and Management services for a major procedure (90-day period) that are reported 1-day preoperatively, on the same date of service or during the 90-day postoperative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with "MMM - Global periods" for maternity services are classified as " MMM" when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility; they are considered bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

CPT and HCPCS manuals

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime. Code editing will fire a frequency edit when the procedure code is billed in excess of these guidelines.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

MUE's reflect the maximum number of units that a provider would bill for a single member, on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyst, equipment prescribing information and clinical judgment.

Duplicate Edits

Code editing will evaluate prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician bill for office visits for the same member on the same day.

Same-Day, Co-Located Services

SilverSummit Healthplan permits same-day billing where appropriate. The system is configured to allow claims for both primary and behavioral health services provided on the same day and at the same location. For example, a family medicine (primary care) provider and clinical social worker (specialist) with the same TIN, can bill for the same member, on the same date of service and at the same location.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid revenue to procedure code editing

Identifies revenue codes billed with incorrect CPT/HCPCS codes.

Assistant Surgeon

Rule evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

CMS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co or team surgeon.

Add-on and Base Code Edits

Rules look for claims where the add-on CPT code was billed without the primary service CPT code or if the primary service code was denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims where the modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50. This rule is highly customized as many health plans allow this type of billing.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the same provider bills more than one outpatient consultation code for the same member in the member's history. This rule will deny the office consultation code and replace it with a more appropriate evaluation and management service, established patient or subsequent hospital care code. Another example, the rule will evaluate if a provider has billed a new patient evaluation and management code within three years of a previous new patient visit. This rule will replace the second submission with the appropriate established patient visit. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes
- Deleted Codes: Evaluates claims for procedure codes which have been deleted
- Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations
- This rule analyzes modifiers affecting payment. As an example, modifiers - 24, -25, -26, -57, -58 and -59
- Age Rules: Identifies procedures inconsistent with member's age
- Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. Examples of SilverSummit Healthplan's clinical validation services are modifiers -25 and -59 review. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1." Furthermore, public-domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). SilverSummit Healthplan's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

MODIFIER -59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier 59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier - 59 as follows: "Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

Some providers are routinely assigning modifier 59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier 59 related to the portion of the definition that allows its use to describe "different procedure or surgery". NCCI guidelines state that providers should not use modifier 59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier 59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

SilverSummit Healthplan uses the following guidelines to determine if modifier-59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites

- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately

To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier 25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a "significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service". Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

SilverSummit Healthplan uses the following guidelines to determine whether or not modifier 25 was used appropriately.

If any one of the following conditions is met then, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member's need for additional services
- To avoid incorrect denials providers should assign all applicable diagnosis codes that support additional E/M services

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and are considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Payment and Coverage Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective audits. These policies are posted on each health plan's provider portal when appropriate. These policies are highly customizable and may not be applicable to all health plans.

Claim Reconsiderations related to Code Auditing and Editing

Claims appeals resulting from claim-editing are handled per the provider claims appeals process outlined in this manual. When submitting claims appeals, please submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code audit or edit and request claim reconsideration, you must submit medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code audit or edit will be upheld.

Viewing Claim Coding Edits

Code Editing Assistant

A web-based code auditing reference tool designed to "mirror" how the code auditing product(s) evaluate code and code combinations during the auditing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking "Claim Auditing Tool" in our secure provider portal.

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 be used to determine if an edit is appropriate.

The code editing assistant can be accessed from the provider web portal.

Disclaimer

This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Other Important Information

Health Care Acquired Conditions (HCAC) – Inpatient Hospital

SilverSummit Healthplan follows Medicare's policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare's most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim. POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

Reporting and Non-Payment for Provider Preventable Conditions (PPCS)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by SilverSummit Healthplan for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment.

Non-Payment and Reporting Requirements Provider Preventable Conditions (PPCS) - Inpatient

SilverSummit Healthplan follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported. If covered services/procedures are also provided during the same stay, the health plan follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim. Inpatient hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no-pay TOB claim. SilverSummit Healthplan follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/ procedure (as a PPC) is reported.

Other Provider Preventable Conditions (OPPCS) – Outpatient

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Conditions currently identified by CMS include:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive surgery performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Non-Payment and Reporting Requirements Other Provider Preventable Conditions (OPPCs) – Outpatient

Medicaid follows the Medicare guidelines and NCDs, including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).

Lesser of Language

Unless specifically contracted otherwise, SilverSummit Healthplan's policy is to pay the lesser of billed charges and negotiated rate.

- Example 1 – Code 12345 – Billed $600. Negotiated Rate is $500. MCO pays $500 negotiated rate
- Example 2 – Code 12345 – Billed $500. Negotiated Rate is $600. MCO pays $500 billed rate

Timely Filing

Providers must submit all claims, encounters and corrected claims within 180 calendar days of the date of service or date of eligibility. When SilverSummit Healthplan is the secondary payer, claims must be received within 365 calendar days from the date of service or date of eligibility.

All claim requests for reconsideration, or claim disputes must be received within 60 calendar days from the date of Remittance Advice (RA) of payment or denial is issued.

Use of Assistant Surgeons

An Assistant Surgeon is defined as a physician who utilizes professional skills to assist the Primary Surgeon on a specific procedure. All Assistant Surgeon's procedures are subject to retrospective review for Medical Necessity by Medical Management. All Assistant Surgeon's procedures are subject to health plan policies and are not subject to policies established by contracted hospitals.

Hospital medical staff by laws that require an Assistant Surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity. Nor is reimbursement guaranteed when the patient or family requests an Assistant Surgeon be present for the surgery. Coverage and subsequent reimbursement for an Assistant Surgeon's service is based on the medical necessity of the procedure itself and the Assistant Surgeon's presence at the procedure.

Appeals And Grievances

For appeals & grievances, see the SilverSummit Healthplan Provider Manual located on the Provider Resources page of our website.

Corrected Claims, Reconsiderations, and Claim Appeals

Except in the case of fraud or being related to coordination of benefits with another carrier, all requests for corrected claims, reconsiderations, or claim disputes must be received within 60 days from the from the date of the Medicaid Remittance. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes received outside of the 60 day timeframe. For coordination of benefits with another carrier, requests must be received within 365 days.

Relevant Claim Definitions

- Corrected claim – A provider is changing the original claim
- Request for reconsideration – Submitted when a provider disagrees with how a clean or adjusted claim was processed (payment amount, denial reason, etc.)
- Claim Appeal– A provider disagrees with the claim outcome and is submitting medical records or other documentation to support the disagreement

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the Secure Provider Portal. Follow the instructions on the portal for submitting a correction
- Submit a corrected claim electronically via a clearinghouse
  - Institutional Claims (UB): Field CLM05-3=7 and REF*8 = Original Claim Number
  - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number

- Submit a corrected paper claim to:

  SilverSummit Healthplan
  Attn: Corrected Claim
  PO Box 5090
  Farmington, MO 63640-5090

- Upon submission of a corrected paper claim, the original claim number must be typed in field 22 (CMS 1500) and in field 64 CMS 1450 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.

Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be rejected upfront.

Request for Reconsideration

A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. An example can include but are not limited to:

- Denials related to code edits or authorization. Requests related to code edit or authorization denial require medical records and must accompany the request for reconsideration
- Payment amount which does not align with expected reimbursement amount

Requests for reconsideration can be submitted in one of the following ways:

- Providers may elect to call Provider Services at 1-844-366-2880 to explain the request
- Providers may send a written letter with our required reconsideration form that includes a detailed description of the reason for the request. To ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, the member name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number. Mail requests for reconsideration and any applicable attachments to:

  SilverSummit Healthplan
  Attn: Claims Department
  P.O. Box 5090
  Farmington, MO 63640-5090

The outcome of the Request for Reconsideration is communicated to the provider. An overturned request will result in a reprocessed claim with a new reason code. A written or verbal communication is shared with the provider when reconsideration requests result in upholding the original decision.

Claim Appeal

A provider claim payment appeal is not a member appeal (or a provider appeal on behalf of a member). A claim appeal should be submitted when a provider has received an unsatisfactory response to a previous reconsideration request and believes additional information will result in a different outcome. Oftentimes, additional information is contained within medical records. Claim appeals can be submitted via mail or the Provider Portal. Appeals must include an explanation outlining why the original decision is incorrect, along with specific medical records supporting the suggested outcome.

A claim appeal can be must be submitted with our required Claim Appeal Form found on our website https://www.silversummithealthplan.com/providers/resources/formsresources.html under Provider Forms, if the dispute is submitted via mail. The claim appeal form must be completed in its entirety. DO NOT include a copy of the original claim form with your appeal. Please submit one claim per appeal form.

Mail completed claim appeal forms and additional information to be considered to:

SilverSummit Healthplan
Attn: Appeals & Grievances
P.O. Box 5090
Farmington, MO 63640-5090

If the original decision is upheld, a written letter will be sent that includes the rationale for upholding the decision. If the original decision is overturned the claim will be reprocessed with a new reason code.

NOTE: Pre- or Post- service Authorization Appeals, related to Medical Necessity Appeals, may be filed by a provider with knowledge of a member's medical condition. A provider may also file an appeal on behalf of a member with the member's written consent. Please follow the authorization appeal process within our SilverSummit Healthplan Provider Manual located on the Provider Resources page of our website.

Required Reconsideration Request Form

DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.

Reason for the reconsideration (please check all that apply):

- ☐ Sterilization consent form
- ☐ Primary insurance EOP
- ☐ Invoice
- ☐ Itemized bill (inpatient hospital claims or as requested)
- ☐ Unlisted procedure code documentation
- ☐ Medical records related to a claim denial (NOT related to a medical necessity appeal)
- ☐ Claim was denied for no authorization, but authorization number _____ was obtained
- ☐ Claim was denied due to lack of Nevada Provider Medicaid enrollment. The IPN is: _____
- ☐ Claim was not paid per the terms of my contract with SilverSummit Healthplan Please explain and advise of your payment expectation/amount: _____
- ☐ Other, please explain: _____

Note: No form is required for the submission of corrected claims. For corrected claims, please use the claims resubmission process outlined in the provider manual.

Provider Name: _____ Provider TIN Number: _____

Medicaid Provider Number: _____ Provider Contact Number: _____

Contact Name: _____ Contact Address: _____

Member Name: _____ Members Medicaid Number: _____

Date(s) of Service: _____ Claim Number(s): _____

Medicaid Remittance Date: _____ Billed Charge(s): _____

MAIL COMPLETED FORMS AND ALL ATTACHMENTS TO:

SilverSummit Healthplan
PO Box 5090
Farmington, MO 63640-5090

SilverSummit Healthplan will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you an updated EOP with the denial reasoning). If we overturn our original decision, we will send you an updated EOP stating our decision and any additional payment due will appear on the provider remittance. This form may be photocopied.

Required Claim Appeal Form

DO NOT USE THIS FORM FOR A RECONSIDERATION REQUEST.
USE THE "RECONSIDERATION REQUEST FORM".

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the appeal. Any appeal request received with an incomplete form and/or missing documentation cannot be reviewed and will be returned to you for completion.

Provider Name: Provider TIN Number:

Medicaid Provider Number: Provider Contact Number:

Contact Name: Contact Address:

Member Name: Members Medicaid Number:

Date(s) of Service: Claim Number(s):

Medicaid Remittance Date: Billed Charge(s):

Reason for the appeal (please check all that apply):

- ☐ Claim was denied for no authorization, but authorization number _____ was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for no authorization; however, authorization was not obtained due to member's eligibility or medical condition.
- ☐ Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- ☐ Claim was not paid per the terms of my contract with SilverSummit Healthplan (attach relevant reimbursement section).
- ☐ Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- ☐ Claim was denied "Past Timely Filing" (attach proof of timely filing).
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- ☐ Claim denied based on SilverSummit HealthPlan's payment policy (attach medical records to support services provided). Note: Payment policies can be found at https://www.silversummithealthplan.com/providers/resources/COPY_clinical-payment- policies.html
- ☐ Other. Please explain (and provide supporting documentation): _____

MAIL COMPLETED FORMS AND ALL ATTACHMENTS TO:
SilverSummit Healthplan
PO Box 5090
Farmington, MO 63640-5090

SilverSummit Healthplan will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you a letter stating we are upholding our original decision and state our reason(s) for the decision or overturn our original decision). If we overturn our original decision, we will send you a letter stating our decision and any additional payment due will appear on the provider remittance. This form may be photocopied.

Other Relevant Billing Information

Interim Claims

Interim hospital encounters are allowed as long as the length of stay is greater than 30 days. However, second, third, fourth, final interim encounters must be submitted as an adjustment to the original claim and must contain all dates of service from admission through to the last service date included on the claim. Only one interim claim is allowed, the remaining must be adjusted to the original claim.

Appendix 1: Common 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.

Code	Description
1	Invalid Mbr DOB
2	Invalid Mbr
6	Invalid Prv
7	Invalid Mbr DOB & Prv
8	Invalid Mbr & Prv
9	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
23	Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
38	Mbr not valid at DOS; Prov not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prov not valid at DOS; Invalid Diag
40	Invalid Prov; Invalid Proc
41	Invalid Mbr DOB; Invalid Prov; Invalid Proc
42	Invalid Mbr; Invalid Prov; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prov not valid at DOS; Invalid Proc

Code	Description
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prov; Invalid Proc
51	Invalid Diag; Invalid Proc
74	Services Performed prior to Contract Effective Date
75	Invalid units of service

Appendix 2: Instructions for Supplemental Information

CMS-1500 (2/12) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (2/12) 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.	**ZZ** Narrative description of unspecified/miscellaneous/unlisted codes **N4** National Drug Codes (NDC) **CTR** Contract Rate	
The following qualifiers are to be used when reporting NDC units:	**F2** International Unit **GR** Gram	**ML** Milliliter **UN** Unit

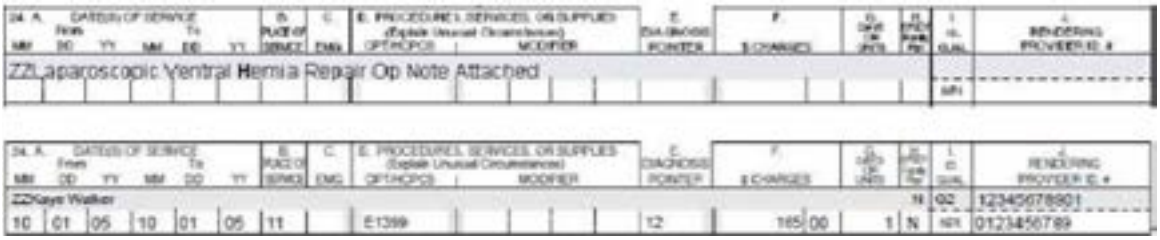
To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

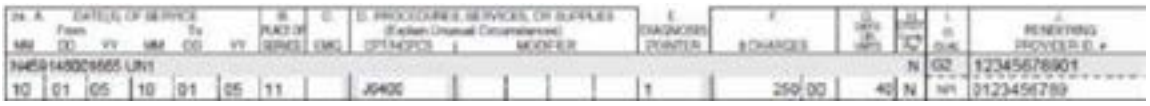
More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (ex. 1000.00; 123.45).

Unspecified/Miscellaneous/Unlisted Codes



NDC Codes



Appendix 3: Instructions for Submitting NDC Information

Instructions for Entering the NDC:

(Use the guidelines noted below for all claim types including WebPortal submission)

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.

837I/837P		
Data Element	**Loop**	**Segment/Element**
NDC	2410	LIN03
Unit of Measure	2410	CTP05-01
Unit Price	2410	CTP03
Quantity	2410	CTP04

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

Paper Claim	Field
CMS 1500 (02/12)	24 A (shaded claim line)
UB04	43

Facility

Paper, use Form Locator 43 of the CMS1450 and UB04 (with the corresponding HCPCS code in Locator 44) for Outpatient and Facility Dialysis Revenue Codes 250 – 259 and 634 – 636.

Physician

Paper, use 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	**ML** Milliliter **ME** Milligram **UN** Unit

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CMS 1500 (2/12) Claim Form Instructions

Require (R) Fields must be completed on all claims.	**Conditional (C)** fields must be completed if the information applies to the situation, or the service provided.	**Note**: Claims with missing or invalid Required (R) field information will be rejected of denied.

Field	Field Description	Instruction or Comments	Required or Conditional
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other."	Not Required
1a	Insured's I.D. Number	The 9-digit identification number on the member's Health Plan I.D. Card.	R
2	Patient Name (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Health Plan I.D. card. Do not use nicknames.	R
3	Patient's Birth Date / Sex	Enter the patient's 8 digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female.	R
4	Insured's Name	Enter the patient's name as it appears on the member's Health Plan I.D. Card.	R
5	Patient's Address (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	R
6	Patient's Relation To	Always mark to indicate self.	C
7	Insured's Address (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	Not Required
8	Reserved for NUCC USE		Not Required
9	Other Insured's Name (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*Other Insured's Policy or Group Number	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	Reserved for NUCC USE		Not Required
9c	Reserved for NUCC USE		Not Required

Field	Field Description	Instruction or Comments	Required or Conditional
9d	Insurance Plan Name or Program Name	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10 a, b, c	Is Patient's condition related to	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	Reserved for Local Use		Not Required
11	Insured Policy or FECA Number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	Insured's Date of Birth / Sex	Enter the 8-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.	C
11b	Other Claim ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	C
11c	Insurance Plan Name or Program Number	Enter name of the insurance health plan or program.	C
11d	Is there another Health Benefit Plan?	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	R
13	Insured's or Authorized Persons Signature	Obtain signature if appropriate.	Not Required
14	Date of Current: Illness (First Symptom) or Injury or (Accident) or Pregnancy (LMP)	Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period.	C

Field	Field Description	Instruction or Comments	Required or Conditional
15	Other Date	Enter another date related to the patient's condition or treatment. Enter the date in the six digit (MM|DD|YY) or eight digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported: 454 Initial Treatment 304 Latest visit or Consultation 453 Acute manifestation of a Chronic Condition 439 Accident 455 Last X-ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the patient's condition or treatment.	C
16	Dates patient unable to work in current occupation	If the patient is employed and is unable to work in current occupation, a six digit (MM/DD/YY) or eight digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.	C
17	Name of referring physician or other source	Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the laim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring provider 2. Ordering provider 3. Supervising provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported: DN Referring provider DK Ordering provider DQ Supervising provider Enter the qualifier to the left of the vertical, dotted line.	C
17a	Referring physician	Required if 17 is completed. Use ZZ qualifier for taxonomy code. Must bill taxonomy provider is attested to.	C
17b	NPI number of referring physician	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	Hospitalization dates related to current Services		C
19	Reserved for local use – new form: additional claim information		C

Field	Field Description	Instruction or Comments	Required or Conditional
20	Outside Lab /Charges	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in block 32.	C
21	Diagnosis or Nature of Illness or Injury. (Relate Items A-L to service line below (24E)	The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. Enter the applicable ICD indicator to identify which version of ICD codes is being reported: 0 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-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Claims missing or with invalid diagnosis codes will be denied for payment.**	R
22	Resubmission code/ original Ref. no.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	Prior Authorization Number or CLIA Number	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If CLIA = R (If both, always submit the CLIA number)
24 A-G Shaded	Supplemental information	The shaded top portion of each service claim line is used to report supplemental information for: **NDC** – Narrative description of unspecified codes **Contract Rate** – For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24A unshaded	Dates of Service	Enter the date the service listed in 24D was performed (MM/DD/YY). If there is only one date, enter that date in the From field. The To field may be left blank or populated with the From date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R
24B unshaded	Place of Service	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24C unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	R

Field	Field Description	Instruction or Comments	Required or Conditional
24D unshaded	Procedures, Services or Supplies CPT/HCPCS Modifier	Enter the five digit CPT or HCPC code and two character modifier if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. The following national modifiers are recognized as modifiers that will impact the pricing of your claim. 	R
24E unshaded	Diagnosis Pointer	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM or ICD-10- CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24F unshaded	Charges	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24G unshaded	Days or Units	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24H shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24H unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24I shaded	ID Qualifier	Use ZZ qualifier for Taxonomy. Use 1D qualifier for ID, if an Atypical Provider.	R
24J shaded	Taxonomy Code	**Typical Providers**: Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. **Atypical Providers**: Enter the Provider ID number.	R

Field	Field Description	Instruction or Comments	Required or Conditional
24J unshaded	NPI Provider ID	**Typical Providers ONLY**: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-charac-ter NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	Federal Tax I.D. Number SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID.	R
26	Patient's Account No.	Enter the provider's billing account number.	Not Required
27	Accept Assignment?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Health Plan recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	Total Charges	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Health Plan. Medicaid programs are always the payers of last resort.	R
29	Amount Paid	Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. REQUIRED when field 29 is completed.	C
30	Balance Due	Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	Not Required
31	Signature of physician or supplier including degrees or credentials	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. **Note**: Does not exist in the electronic 837P.	R

Field	Field Description	Instruction or Comments	Required or Conditional
32	Service facility location information	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, peri-ods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – Services Rendered	**Typical Providers ONLY**: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered. REQUIRED if the location where services were rendered is different from the billing address listed in field 33.	C
32b	Other Provider ID	**Typical Providers**: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). **Atypical Providers**: Enter the 2-character qualifier 1D (no spaces).	C
33	Billing provider info & ph#	Enter the billing provider's complete name, address (include the zip +4 code), and phone number. First line - Enter the business/facility/ practice name. Second line - Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line -Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number. (i.e. (555)555-5555). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	R
33a	Group Billing NPI	**Typical Providers ONLY**: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	Group Billing Other ID	Enter as designated below the Billing Group taxonomy code. **Typical Providers**: Enter the Provider Taxonomy Code. Use ZZ qualifier. **Atypical Providers**: Enter the Provider ID number.	R

Appendix 5: Claims Form Instructons – UB

UB-04/CMS 1450 (2/12) Claim Form Instructions

Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by SilverSummit Healthplan. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/ encounter being rejected for correction.

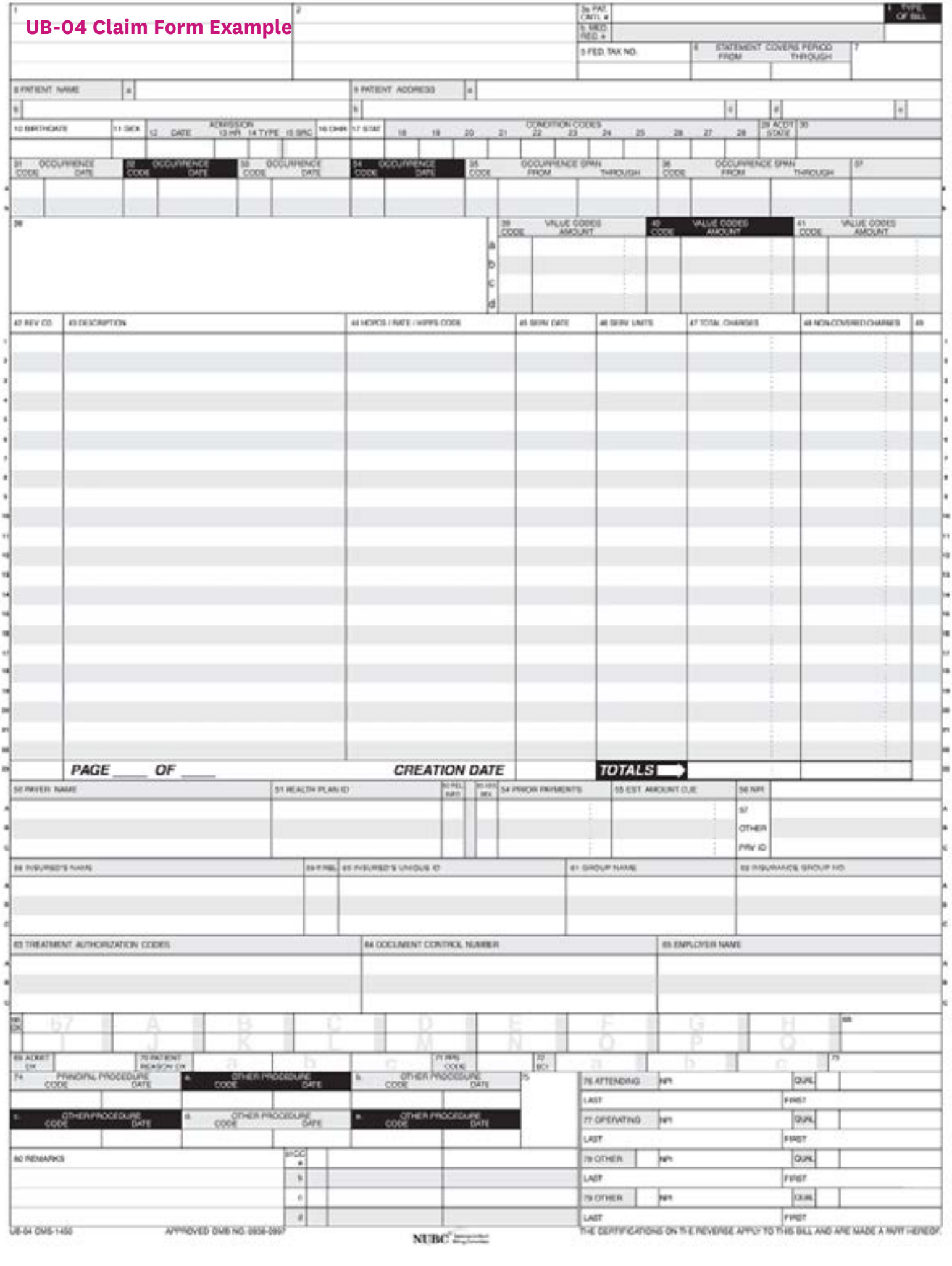
UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.

Please refer to your provider contract with SilverSummit Healthplan or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

UB-04 Claim Form Example



UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-04 Claim Form

Require (R) Fields must be completed on all claims.	**Conditional (C)** fields must be completed if the information applies to the situation, or the service provided.	**Note**: Claims with missing or invalid Required (R) field information will be rejected of denied.

Field	Field Description	Instruction or Comments	Required or Conditional
1	Unlabeled Field	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9 digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	Unlabeled Field	Enter the Pay - to Name and Address.	Not Required
3a	Patient Control Number	Enter the facility patient account/control number.	Not Required
3b	Medical Record Number	Enter the facility patient medical or health record number.	R
4	Type of Bill	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	R
5	Fed. Tax no	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	Statement covers Period from/through	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	Unlabeled Field	Not used.	Not Required
8a	Patient Name	8a – Enter the first 9 digits of the identification number on the member's Health Plan I.D. card	Not Required
8b		8b – Enter the patient's last name, first name, and middle initial as it appears on the Health Plan ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g. McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix.	R
9	Patient Address	Enter the patient's complete mailing address of the patient. Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	Birthdate	Enter the patient's date of birth (MMDDYYYY).	R
11	Sex	Enter the patient's sex. Only M or F is accepted.	R
12	Admission Date	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R

Field	Field Description	Instruction or Comments	Required or Conditional
13	Admission Hour	Enter the time using two digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	R
14	Admission Type	Required for inpatient admissions TOB 11X, 118X, 21X, 41X. Enter the one digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	Admission Source	Enter the one digit code indicating the source of the admission or outpatient service using one of the following codes: For Type of admission 1,2,3 or 5: 1 Physician referral 2 Clinic referral 3 Health maintenance referral (HMO) 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available	R
16	Discharge Hour	Enter the time using two digit military time (00-23) for the time of inpatient or outpatient discharge. Discharge Hour must be left blank for Discharge Status 30. 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	C

Field	Field Description	Instruction or Comments	Required or Conditional
17	Patient Status	REQUIRED for inpatient and outpatient claims. Enter the 2 digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH) 71 Discharged to another institution of outpatient services 72 Discharged to another institution	R
18-28	Condition Codes	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).	C
29	Accident State	For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	Not Required
30	Unlabeled Field		Not Required

Field	Field Description	Instruction or Comments	Required or Conditional
31-34 a-b	Occurrence Code and Occurrence Date	Occurrence Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual. Occurrence Date: Required when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MM/DD/YYYY format. Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61,62, and 80 must also be completed as required. Refer to Subsection 6.6.5, Occurrence Codes, in this section. Use one of the following codes if applicable: 01 Auto accident/auto liability insurance involved 02 Auto or other accident/no fault involved 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim 10 Last menstrual period 11 Onset of symptoms 16 Date of last therapy 17 Date outpatient OT plan established or last reviewed 24 Date other insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan of treatment was established 29 Date outpatient PT plan established or last reviewed 30 Date outpatient speech pathology plan established or last reviewed 35 Date treatment started for PT 44 Date treatment started for OT 45 Date treatment started for speech language pathology (SLP) 50 Date other insurance paid 51 Date claim filed with other insurance 52 Date renal dialysis initiated	C
35-36 a-b	Occurrence Span Code and Occurrence Date	Occurrence Span Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual. Occurrence Span Date: Required when applicable or when a corresponding Occurrence Span Code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MM/DD/YYYY format. For inpatient claims, enter code 71 if this hospital admission is a readmission within seven Days of a previous stay. Enter the dates of the previous stay.	C
37	Unlabeled Field	Required for resubmissions or adjustments. Enter the 12 character document control number (DCN) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with “resubmission” to avoid denials for duplicate submission. Note: For resubmissions submitted via EDI, the CLM05-3 must be “7” and in the 2300 loop a REF “F8” must be sent with the original claim number.	C
38	Responsible Party Name and Address		Not Required

Field	Field Description	Instruction or Comments	Required or Conditional
39-41 a-d	Value Codes Codes and Amounts	**Code: REQUIRED when applicable.** Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. Accident hour: For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.	C
General	Revenue Codes and Description	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	Description	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e. PAGE "1" OF "1"). (Limited to 4 pages per claim)	C
43 Line 23	Page ___ of ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e. PAGE "1" OF "1"). (Limited to 4 pages per claim)	C

Field	Field Description	Instruction or Comments	Required or Conditional
44	HCPCS/Rates	**REQUIRED for outpatient claims when an appropriate** CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modi-fier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete list-ing of revenue codes and instructions. Please refer to your current provider contract	C
45 Lines 1-22	Service Date	**REQUIRED on all outpatient claims.** Enter the date of service for each service line	C
45 Line 23	Creation Date	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	Service Units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed	R
47 Lines 1-22	Total Charges	Enter the total charge for each service line	R
47 Line 23	Totals	Enter the total charges for all service lines	R
48 Lines 1-22	Non-Covered Charges	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	Totals	Enter the total non-covered charges for all service lines.	C
49	(Unlabeled Field)	Not Used	Not Required
50 A-C	Payer	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	Health Plan Identification Number		Not Required
52 A-C	Related Information	Required for each line (A, B, C) completed in field 50, Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y"	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authoriz-ing payment by the payer directly to the provider for services.	R
54	Prior Payments	Enter the amount received from the primary payer on the appropri-ate line when Medicaid is listed as secondary or tertiary.	C
55	Est. Amount Due		Not Required
56	National Provider Identifier or Provider ID	Required: Enter providers 10- character NPI ID.	R
57	Other Provider ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider.	R
58	Insured's Name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	Patient Relationship		Not Required
60	Insured's Unique ID	**REQUIRED:** Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	Group Name		Not Required
62	Insurance Group Number		Not Required
63	Treatment Authorization Codes	Enter the Prior Authorization or referral when services require pre-certification.	C

Field	Field Description	Instruction or Comments	Required or Conditional
64	Document Control Number	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting the Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	Employer Name		Not Required
66	DX Version Qualifier		Not Required
67	Principal Diagnosis Code	Enter the principal/primary diagnosis or condition using the appro-priate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.	R
67 A-Q	Other Diagnosis Code	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity –or"5" digit. "E" and most 4th "V" codes are **NOT** acceptable as a primary diagnosis. **Note:** Claims with incomplete or invalid diagnosis codes will be denied.	C
68	Present on Admission Indicator		R
69	Admitting Diagnosis Code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or"5" digit. "E" codes and most "V" are **NOT** acceptable as a primary diagnosis. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R
70	Patient Reason Code	Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or"5". "E" codes and most "V" codes are **NOT** acceptable as a primary diag-nosis. **NOTE:** Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG Code		Not Required
72 a, b, c	External Cause Code		Not Required
73	Unlabeled		Not Required
74	Principal Procedure Code/Date	**CODE:** Enter the ICD-9/10 Procedure Code that identifies the prin-cipal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. **DATE:** Enter the date the principal procedure was performed (MMDDYY)	C
74 a-e	Other Procedure Code Date	**REQUIRED** on inpatient claims when a procedure is performed during the date span of the bill. **CODE:** Enter the ICD-9/ICD-10 procedure code(s) that identify signif-icant procedure(s) performed other than the principal/primary procedure. Up to five ICD9/ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. **DATE:** Enter the date the principal procedure was performed (MMDDYY).	C
75	Unlabeled		Not Required

Field	Field Description	Instruction or Comments	Required or Conditional
76	Attending Physician	Enter the NPI and name of the physician in charge of the patient care. **NPI:** Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. **QUAL:** Enter one of the following qualifier and ID number: **0B** – State License #. **1G** – Provider UPIN. **G2** – Provider Commercial #. **B3** – Taxonomy Code. **LAST:** Enter the attending physician's last name. **FIRST:** Enter the attending physician's first name.	R
77	Operating Physician	REQUIRED when a surgical procedure is performed.	C
		Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. **QUAL:** Enter one of the following qualifier and ID number: **0B** – State License #. **1G** – Provider UPIN. **G2** – Provider Commercial #. **B3** – Taxonomy Code. **LAST:** Enter the attending physician's last name. **FIRST:** Enter the attending physician's first name.	
78 & 79	Other Physician	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider Type Qualifiers: **DN** – Referring Provider. **ZZ** – Other Operating MD. **82** – Rendering Provider. **NPI:** Enter the other physician 10-character NPI ID. **QUAL**: Enter one of the following qualifier and ID number: **0B** - State license number **1G** - Provider UPIN number **G2** - Provider commercial number	C
80	Remarks		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7-digit Provider number of ordering physician.	R

Appendix 6: Origin And Destination Modifiers For Transportation

Origin and Destination Modifiers for Transportation:

When ambulance services are reported, the name of the hospital or facility should be included on the claim. If reporting the scene of an accident or acute event (character S) as the origin of the recipient, a written description of the actual location of the scene or event must be included with the claim(s).

D: Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes

E: Residential, domiciliary, custodial facility (other than 1819 facility)

G: Hospital-based ESRD facility

H: Hospital

I: Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transfer

A: Freestanding ESRD facility

N: Skilled nursing facility (SNF)

P: Physician's office

R: Residence

S: Scene of accident or acute event

X: Intermediate stop at physician's office on way to hospital (destination code only)

Note: Modifier X can be used only as a second position modifier representing a destination code.

Based on the modifiers noted above, the following are all valid combinations for the first modifier fields:

DD	ED	GD	HE	ID	JD	ND	PD	RD	SH
DE	EE	GE	HH	IE	JE	NE	PE	RE	SI
DG	EG	GH	HI	IG	JG	NG	PG	RG	SX
DH	EH	GI	HJ	II	JH	NH	PH	RH	
DI	EI	GJ	HN	IJ	JJ	NI	PI	RI	
DJ	EJ	GN	HP	IN	JN	NJ	PJ	RJ	
DN	EN	GP	HR	IP	JP	NN	PN	RN	
DP	EP	GR	HX	IR	JR	NP	PP	RP	
DR	ER	GX		IX	JX	NR	PR	RX	
DX	EX					NX	PX		

Appendix 7: State Specific Modifiers

MODIFIER	DESCRIPTION
RP	Replacement and Repair-RP may be used to indicate replacement of DME
QB	Physician providing service in a rural HPSA