

HOME HEALTH

Provider Manual
Volume II

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New Hampshire
Medicaid



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1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the NH Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The Appendices section encompasses a wide range of supplemental materials such as Fee Schedules, Contact Information, Provider Type List, Sample Forms and Instructions, as well as other general information.
- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for health care providers, their staff, and provider-designated billing agents.

These manuals are *not* designed for use by NH Medicaid members (hereinafter referred to as members).

Provider Accountability

Providers should maintain both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

Document Disclaimer/Policy Interpretation

It is our intention that the provider billing manuals, as well as the information furnished to providers by the Communications staff of Xerox, the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between Xerox and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

Notifications & Updates

Providers are notified of NH Medicaid Program changes and any other changes applicable to participating providers through several types of media including provider bulletins, provider notices, memos, letters, web site updates, newsletters and/or updated pages to the General Billing Manual – Volume I and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their billing agents and staff.

Billing Manual updates are distributed jointly by the Department and Xerox. Providers receive notification of manual updates through a message sent to each provider's message center inbox via the web.

Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the Xerox Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the Xerox Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

All participating home health services providers shall:

1. Hold a current New Hampshire state license as a Home Health Care Provider, in accordance with RSA 151;
2. Be certified to participate in the Medicare Program; and
3. Be an enrolled NH Medicaid provider.

When there is no licensed and certified home health services provider in the area, a registered nurse may provide home health services if the registered nurse:

1. Is currently licensed to practice in the state in which he/she practices;
2. Receives written orders from the member's physician;
3. Documents the care and services provided in accordance with He-W 553;
4. Has had orientation to acceptable clinical and administrative record keeping from a health department nurse; and
5. Is a NH-enrolled Medicaid provider of home health services.

3. Covered Services & Requirements

Covered services are those home health services, the need for which is consistent with the nature of the member's condition and accepted standards of medical and nursing practice. A member does not have to be homebound. However, home health services must be provided in the member's place of residence. Place of residence does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF /IID), except that home health services may be provided in an ICF/IID for a short term, acute care illness if the service is not required to be provided by the facility and the provision of the service prevents the member's transfer to a nursing facility.

Home health covered services include:

1. Skilled nursing services including:
 - Skilled observation and assessment of the member's status, including available support system and physical environment;
 - Administration of medications, including intramuscular and intravenous medications;
 - Insertion and irrigation of indwelling urinary catheters;
 - Administration of enemas, providing ostomy care, and other related procedures to provide assistance with bowel evacuation;
 - Skilled respiratory care including suctioning, tracheostomy care, administration of inhalation therapies, and chest physiotherapy;
 - Wound care, care of decubitus ulcers, and treatment of other extensive skin disorders;
 - Administration of enteral feedings;
 - Rehabilitative nursing procedures such as the initiation and supervision of bowel and bladder training programs;
 - Education, specific to the member's condition, provided to the member and significant others involved with the member; and
 - Pre-filling of medication administration devices such as pill planners;

2. Home health aide services including assistance provided to a member for the following:
 - Personal hygiene, including bathing, grooming, dressing, and changing bed linens when there is a medical need/care plan for such assistance;
 - Ambulation and movement, including range of motion exercises, turning, positioning, and transferring;
 - Nutritional care, including feeding and hydration;
 - Elimination, including toileting and bowel/bladder training;
 - Assistance with the use of adaptive prosthetic and orthotic devices;
 - Assistance with self-administering medications, when the assistance provided by the aide does not require the skill of a licensed nurse;
 - Administration of medications by a medication licensed nursing assistant;
 - Activities that are directly supportive of skilled therapy services;

- Other medically related activities which can safely and effectively be provided by a licensed home health aide, including simple dressing changes;
 - Services such as light housekeeping and meal preparation only when there is documentation that no other support in the home exists, and only when such services are directly related to the member's medical condition and care needs; and
 - Tasks properly delegated to the home health aide by the supervising licensed nurse.
3. Physical, occupational, and speech therapy subject to the service limits specified for these services in the Provider Specific Billing Manual – Volume II, for these services;
 4. Durable medical equipment, medical supplies, prosthetics and orthotics when prescribed by the attending physician; and
 5. Office visits when the member receives services provided by an advanced practice registered nurse at the location of the home health services provider as an alternative to visiting a physician's office for treatment.

Please note that home health agencies can also bill one occurrence of a newborn home visit if the visit is conducted within 60-days of the birth of the infant, and if the mother is NH Medicaid eligible. This visit is billed under the mother's NH Medicaid identification number. Newborn home visits are covered if provided by home health agencies in accordance with the newborn home visit rule at He-W 547, and are considered to be "newborn home visit services," not "home health services."

Service Limits

There are no service limits on home health services except for physical, occupational and speech therapies which are subject to the service limits specified in the Provider Specific Billing Manual – Volume II for these services.

4. Non-Covered Services

Non-covered services are those services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those listed below or those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the “Non-Covered Services” section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, prior to delivery of the service, that it is non-covered by NH Medicaid and that should the member still choose to receive the service, then the member is responsible for payment for the service. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that s/he understands that the service is non-covered and that s/he agrees to pay for it.

Non-covered home health services include:

- Physician services;
- Social worker services;
- Nutritionist services;
- Visits provided solely for the purpose of supervising the home health aide;
- Services provided by a home health aide which are not medically related and which constitute routine household activities, day care, or recreational services, except for, as described under covered services above, services such as light housekeeping and meal preparation when there is documentation that no other support in the home exists, and only when such services are directly related to the member’s medical condition and care needs.
- Services rendered without a physician’s signed order;
- Any service whose primary purpose is providing emotional support;
- Any service whose primary purpose is the care or supervision that would be required by any individual of the member’s chronological age;
- Any service whose purpose is to implement follow-through on a behavioral treatment plan;
- Drugs and biologicals;
- Meals delivered to the home; and
- Homemaker services considered to be general household activities, including:
 - a) Preparing meals;
 - b) Keeping a safe environment in areas of the home used by the individual needing the service;
 - c) Changing bed linens;
 - d) Performing house cleaning;
 - e) Rearranging furniture to assure that the member can safely reach necessary supplies or medication;

- f) Completing laundry tasks essential to the member's comfort and cleanliness; and
- g) Assisting the member with purchasing food and helping with the preparation of meals and special diets.

5. Service Authorizations

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization of payment for a specific item or service.

Service authorizations are not required for home health services at this time.

6. Documentation

Home health services providers shall maintain complete and timely records for each member receiving services and for which a claim has been submitted to NH Medicaid for reimbursement. Please see the “Record Keeping” section of the General Billing Manual – Volume I, for general documentation requirements.

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until resolution of any legal action(s) commenced in the six year period, whichever is longer.

Member records related to the provision of home health services shall include all of the following:

1. Written orders for initial home health services and certification of the need for home health services signed by the member’s physician specifying the frequency of medication and treatment to be administered, and the period of time to be covered by the orders.
2. A member history and health assessment completed upon admission by the home health services provider’s registered nurse or appropriate rehabilitation skilled professional in accordance with 42 CFR 484.55(a).
3. Documentation at least every 60 days to indicate review of the member’s health assessment by the registered nurse or appropriate rehabilitation skilled professional in accordance with 42 CFR 484.55(a).
4. A plan of care including:
 - a) The diagnosis related to the member’s need for home health services;
 - b) Other diagnoses;
 - c) An assessment of the member’s mental alertness and cognitive level;
 - d) Measurable member goals;
 - e) Types of services and equipment required;
 - f) Frequency of home health services;
 - g) Anticipated length of treatment;
 - h) Prognosis;
 - i) Rehabilitation potential;
 - j) Functional limitations;
 - k) Activities permitted;
 - l) Nutritional requirements;
 - m) Medications;
 - n) Treatments;
 - o) Safety measures required to protect the member from potential injury;
 - p) Services being provided by non-paid caregivers involved in the member’s treatment and any related education or training needs of the caregivers; and
 - q) Discharge plans.
5. Documentation at least every 60 days, to indicate review of the Plan of Care by the registered nurse or licensed physical therapist in accordance with the member’s physician’s orders.

6. Auditable, paper, or electronic service notes for each service provided to the member identifying:
 - a) Name of member;
 - b) Date of service;
 - c) Location where service was provided, if other than the member's primary residence;
 - d) Primary purpose of the home health service;
 - e) Description of service provided;
 - f) Amount of direct care time spent providing each home health service;
 - g) Condition of the member at the time the service was provided, including the member's ability to participate in the activity;
 - h) Any progress the member has made towards goals identified on the plan of care;
 - i) An explanation of any variation from the prescribed plan of care; and
 - j) Name, title, and written or electronic signature of the individual providing the care.
7. Documentation of any consults or meetings regarding the member's care, which also indicates the results of the consult or meeting.

Verbal orders shall be signed by the physician who issues the order within 30 days of the date the verbal order is issued.

Home health services providers shall make member records available for review by the Department upon the request of the Department.

7. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse. These utilization review activities are required and carried out in accordance with Federal regulations at 42 CFR 455 and 42 CFR 456, and they are done to ensure that accurate and proper reimbursement has been made for care, services and/or supplies that have been provided to a member, and for which a provider has received payment.

Utilization review activities may be conducted prior to payment, following payment, or both. These activities include, but are not limited to, conducting provider reviews. These reviews may be selected at random, generated from member complaints, other providers, anonymous calls, or from the SURS reporting system.

There are various outcomes that may result from Program Integrity review activities. They include, but are not limited to:

- Recovery of erroneous and improper provider payments
- Provider education regarding appropriate documentation to support the submission and payment of claims
- Ensuring that the provider has developed a corrective action plan based on the findings of the review. This includes conducting follow-up reviews to verify that the provider is complying with the corrective action plan, and continues to provide and bill for services provided to members, in accordance with the rules and regulations governing the NH Medicaid Program
- Potential referral to appropriate legal authorities – including the NH Medicaid Fraud Control Unit (MFCU) and the Federal Office of Inspector General (OIG)
- Potential termination from the NH Medicaid Program
- Other administrative actions

If a provider is found to have abused the NH Medicaid Program requirements, the provider may be restricted, through suspension or otherwise, from participating in the NH Medicaid Program for a reasonable period of time. In addition, the provider may also have their claims placed on a prepayment pend or hold status for additional review by the Program Integrity Unit.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume 1.

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the *payer of last resort*. All third party obligations must be exhausted before claims can be submitted to Xerox in accordance with 42 CFR 433.139, except for Medicaid only services and claims for prenatal care of pregnant women or claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire). Additional information on exclusions is outlined in this section or in the General Billing Manual – Volume 1. Providers who receive payment in full from a third party are not required to file zero-payment claims with the NH Medicaid Program.

A provider must first submit a claim to the third party within the third party's time limitations. If a third party or primary insurance plan does not pay at or in excess of the applicable NH Medicaid reimbursement level, a provider may submit a claim to NH Medicaid which is processed based on the applicable reimbursement rate minus any payment received from all other resources. Commercial health insurance coverage often provides a higher payment than does NH Medicaid.

When a third party denies a claim, for any reason, a copy of the notice of denial from the third party *must be included* behind the claim submitted to NH Medicaid. When Medicare denies a claim, a copy of the Explanation of Medicare Benefits must be attached behind the claim that is submitted. For claims not submitted on paper, the Medicare or third-party denial is considered a claim attachment.

Detailed Medicare/Third Party Liability (TPL) information is found in the General Billing Manual, including handling discrepancies in TPL resource information, correcting erroneous TPL information, and exceptions to third party filing requirements.

When a member is also covered by Medicare, the provider must bill Medicare for all services before billing NH Medicaid. The provider must accept assignment of Medicare benefits in order for the claim to “*cross over*” to the NH Medicaid Program. The crossover process works only for Medicare approved services; Medicare denied services and Medicare non-covered services are addressed in this section. NH Medicaid pays crossover claims only if the service is covered by NH Medicaid.

Certain services that are not covered by Medicare *may* be covered by NH Medicaid for dually eligible members. Services identified in the Medicare billing manual and HCPCS coding manuals as non-covered by Medicare may be billed directly to NH Medicaid who will determine whether or not the service is covered and can be reimbursed by NH Medicaid.

This does not apply to QMB Only members whose benefits are limited to the Medicare premiums and payment toward the Medicare deductible and coinsurance. Therefore, if Medicare does not cover the service, there is no NH Medicaid payment available for QMB members.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10. Payment Policies

Reimbursement for home health services shall be based on the type of service delivered, and not on the credentials of the person providing the service.

To receive reimbursement for home health services, the provider shall verify that the member is eligible on the date the service is provided, and submit claims for payment to the Department's fiscal agent.

Skilled nursing services are reimbursed a flat rate per visit, and only for one visit per day, at a rate set by the Department.

A home health aide visit composed of fewer than 8 units (with a unit being 15 minutes) of direct care time is reimbursed a flat rate per *visit* at a rate set by the Department.

A home health aide visit composed of 8 or more units (with a unit being 15 minutes) of direct care time is reimbursed a flat rate per *unit* of direct care time at a rate set by the Department.

Reimbursement to home health providers for physical, occupational, and speech therapy services is made in accordance with fee schedules established by the Department as described in the Provider Specific Billing Manual – Volume II, for physical, occupational and speech therapy.

Reimbursement to home health providers for durable medical equipment, non-routine medical supplies, prosthetics, and orthotics is made as described in the Provider Specific Billing Manuals – Volume II, for these services.

Office visits are reimbursed at rates set by the Department.

Home health services are reimbursed at the lesser of the Department's payment rate or the provider's usual and customary charge.

11. Claims

All providers participating in NH Medicaid must submit claims to the fiscal agent in accordance with NH Medicaid guidelines. Providers should note that NH Medicaid claim completion requirements may be different than those for other payers, previous fiscal agents, or fiscal agents in other states.

Providers participating in the NH Medicaid Program are responsible for timely and accurate billing. If NH Medicaid does not pay due to billing practices of the provider which result in non-payment, the provider cannot not bill the member

Claim completion guidelines in this manual should be followed for instructions on specific fields. The NH Specific Companion Guide, which can be found at www.nhmmis.nh.gov (see provider manuals under the provider tab), should be used for electronic claim filing instructions. While field-by-field requirements are shown for paper claims; the same required data is captured through web portal claim entry and through electronic submissions to EDI. Web portal submissions feature step-by-step claim completion instructions as well as tools such as Online Help to assist providers in correct claim completion.

Regardless of the method claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

The following claim-related topics are found in the General Billing Manual – Volume I:

- Claims Submission via EDI, web portal, paper
- Claims processing – edits & audits, transaction control numbers, line item vs header processing, claim status, remark/EOB codes
- Claim Resubmission
- Claim adjustments and voids
- Medicare cross-overs
- Claims payment
- Remittance Advice

Providers will be notified of payment or denial via a Remittance Advice, usually received in electronic format or via the web portal.

Denied claims should be resubmitted only if the reason for the denial has been corrected.

Paid claims cannot be resubmitted; resubmission of a paid claim will result in a denial as a duplicate. Paid claim corrections must be made through the adjustment process. If a paid claim has a line item denial, the individual line charge can be resubmitted.

Corrected claims and denied line items can be resubmitted only if the denial was due to erroneous, updated or missing information which is now corrected. Providers should never resubmit claims that are currently in process (suspended).

Any claim denied for failure to be submitted or resubmitted in accordance with timely filing standards will not be paid. Denied claims that have been corrected must be resubmitted as a new claims transaction on paper, via the web portal, or electronically via EDI.

Timely Filing

In accordance with federal and state requirements, all providers must submit all initial claims within one year following the earliest date of service on the claim.

Except as noted below, NH Medicaid will **not** pay claims that are **not** submitted within the one-year time frame.

Claims that are beyond the one-year filing limit, that have previously been submitted and denied, must be resubmitted on paper, along with Form 957x, "Override Request" located on the NH MMIS Health Enterprise Portal web site at www.nhmmis.nh.gov. A copy of the RA with the original billing date and the denial circled must also be attached. This resubmission **must** be received **within 15 months** of the date of service. If this time frame is not met, the claim will be denied.

The only other circumstance eligible for consideration under the one-year override process is for claims for NH Medicaid covered services for members whose NH Medicaid eligibility determination was delayed. The claim should be submitted as detailed above.

Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis and procedure codes. One procedure code must be provided for each charge billed.

- For medical services, the NH Medicaid Program requires the use of Health Care Financing Administration Common Procedure Coding System (HCPCS) codes, CPT (Current Procedural Terminology) codes and modifiers.

ICD-9-CM diagnosis codes are required for all services billed on medical forms (CMS-1500). Claims without the required diagnosis or procedure codes will be denied.

Required Claim Attachments

All attachments must be submitted in hardcopy or via fax. Providers that submit claims on paper claims should have the claim attachment stapled behind the claim form. Providers that submit claims electronically or via the NH MMIS Health Enterprise Portal must first submit the claim and obtain a Transaction Control Number (TCN) for the line requiring the attachment. Attachments in hard-copy format must then be sent to the fiscal agent with a cover sheet identifying the TCN for the claim. Failure to provide the TCN on the submitted attachments could result in claim denial due to missing or incomplete information.

Examples of , but not inclusive of, when a claim attachment is required are when another insurer is primary and has denied coverage for the service or a 957x form is required because the filing limit was not met.

12. Claim Completions Requirements for Home Health

Item #	Description	Instructions
1		Check Medicaid
1a.	Insured's ID Number	Required - Enter the NH Title XIX ID number (11 characters) shown on the ID card.
2	Patient's Name	Required - Enter the last name, first name, and middle initial as shown on the ID card.
3	Patient's Birth Date (8 digits), Sex	Required Must be valid date mm/dd/ccyy
4	Insured's Name	Last Name, First Name, MI
5	Patient's Address (Multiple Fields) Member's mailing address	City, State, Zip Code
6	Patient Relationship to Insured	N/A
7	Insured's Address	If selected, city, state, zip code, and telephone. If not selected default to "self".
8	Patient Status	N/A
9	Other Insured's Name	When additional group health coverage exists, enter other insured's full name if it is different from that shown in Item Number 2. Last Name, First Name, MI If Item # 11d is marked, complete fields #9 and #9a-d, otherwise leave blank.
9a.	Other Insured's Policy or Group Number	Situational - provide policy number if applicable. Must be 12 or less alpha-numeric characters.
9b.	Other Insured's Date of Birth	N/A

Item #	Description	Instructions
9 c.	Employer's Name or School Name	N/A
9 d.	Insurance Plan Name or Program Name	Required - if other insurance and 11D= yes enter the NH Medicaid specific 10-digit carrier code Codes can located on the NH MMIS Health Enterprise Portal under documents section
10 a-c	Is Patient's Condition Related To?	Required Enter an X in the correct box to indicate whether one or more of the services described in Item # 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Mark <u>one</u> box only on each line.
10 d.	Reserved for Local Use	
11	Insured's Policy, Group or FECA Number	Situational - Enter the insured's policy or group number as it appears on the insured's health care identification card.
11 a.	Insured's Date of Birth (8 digits)	Must be valid date mmddccyy
11 b.	Insured's Employer's Name or School Number The name of the insured's employer or school.	N/A
11 c.	Insurance Plan or Program Name	N/A
11 d.	Is There Another Health Benefit Plan?	Enter an X in the correct box. If marked "YES," complete #9 and # 9a-d and list denial in #19 or payment in #29. Mark <u>one</u> box only.
12	Patient's or Authorized Person's Signature	N/A
13	Insured's or Authorized Person's Signature	N/A
14	Date of Current Illness, Injury, Pregnancy	Situational - Enter if "YES" is present in Item #10 Must be a valid format mmddccyy

Item #	Description	Instructions
15	If Patient Has Had Same or Similar Illness	Date format mm/dd/ccyy
16	Dates Patient Unable to Work in Current Occupation	Date format mm/dd/ccyy
17	Name of Referring Provider	Required – when billing radiology, Lab, DME Last name, First Name, and MI If multiple providers are involved, enter one provider using the priority order: #\1. Referring Provider, 2. Ordering Provider, 3. Supervising Provider
17 a.	Other ID Number (2 digits)	Use two digit qualifier ZZ and the appropriate Taxonomy Code. Enter up to 9 characters.
17 b.	NPI Number	Enter the NPI number of the referring, ordering, or supervising provider. Entry must be 10 numeric digits.
18	Hospitalization Dates Related to Current Service	Optional Date format mmddccyy
19	Reserved for Local Use	
20	Outside Lab? \$ Charges	“Y” or “N” or Blank. Amount must be between 0 and 999999.
21	Diagnoses or Nature of Illness or Injury	Required – Relate Items #1, #2, #3 or #4 to #24E by line Enter the patient’s diagnosis/condition. List up to four ICD-9-CM diagnosis codes. Do <u>not</u> provide narrative description in this field. Must be a valid diagnosis.
22	Medicaid Resubmission Code	List the original Transaction Control Number (TCN) for resubmitted claims.
23	Service Authorization Number (12 characters)	Required – if applicable enter Service Authorization Number. Must be 12 characters **Not being used at this time**

24 a.	Date(s) of Service (Lines 1-6)	Required - Enter dates of service, from and to. If one date of service only, enter that date under "from." Leave "to" blank or re-enter "from" date. Date format: mmddccyy If services are grouped on the same line they must have the same place of service, procedure code, charge and individual provider. The number of days must correspond to the number of units in #24G.
24 a.	Shaded Area	Required if Applicable-Enter the NDC code, if required, N4, the NDC qualifier should be entered in the first two positions, then the NDC. The NDC units of measure qualifier and NDC quantity should follow:
24 b.	Place of Service (Lines 1-6)	Required - Enter the two-digit code for each item or service. VV Must be numeric characters
24 c.	EMG (Lines 1-6)	N/A
24 d.	Procedures, Services or Supplies (Lines 1-6)	Required - Enter CPT/HCPCS and modifier(s) if applicable. This field accommodates the entry of up to four two-digit modifiers.
24 e.	Diagnosis Pointer (Lines 1-6) The diagnosis code reference number (pointer) as shown in Item 21 to relate the date of service and the procedures performed for the primary diagnosis.	Required ICD-9-CM diagnosis codes must be entered in Item #21 <u>only</u> . Do <u>not</u> enter them in #24E. When multiple services are performed, the primary diagnosis pointer for each service should be listed first, other applicable pointers should follow. The diagnosis pointers(s) should be #1, or #2, or #3, or #4; or multiple numbers. Enter numbers left justified in the field. Do <u>not</u> use commas between the numbers.
24 f.	\$ Charges (Lines 1-6)	Required -Enter the total billed amount for each service. Do <u>not</u> use commas or dollar signs. Negative dollar amounts are <u>not</u> allowed.
24 g.	Days or Units (Lines 1-6)	Required - Enter the number of days or units. If only one service is performed, enter #1.

24 h.	EPSDT/Family Plan (Lines 1-6)	Must be "AV", "ST", "S2", "NU", "Y", "N" or Blank
24 i.	ID Qualifier (Lines 1-6)	<p>Required</p> <p>The Rendering Provider is the provider who rendered or supervised the care.</p> <p>Report the Identification Number in Items #24I and #24J only when different from data recorded in Items #33a and #33b.</p> <p>In the shaded area of #24I, enter the qualifier identifying if the number is a non-NPI.</p> <p>Providers can bill with ZZ for taxonomy (with NPI) or a Medicaid ID qualifier. Must be 2 characters long.</p>
24 j.	Rendering Provider ID Number (Lines 1-6)	If provider has NPI please indicate in the unshaded area. If the provider cannot be assigned an NPI(atypical provider) the Medicaid ID number should be entered in the shaded portion of the field
25	Federal Tax ID Number	Must be 9 characters or less.
26	Patient's Account Number	<p>Required</p> <p>Enter patient account number</p>
27	Accept Assignment	Only one box may be checked.
28	Total Charge Total charges for the services (i.e., total of all charges in 24F)	<p>Required – Enter total charges for the services (i.e., total of all charges in #24F)</p> <p>Must be 9 digits or less.</p>
29	Amount Paid	Total amount the patient or other payers paid on the covered services only. IPL Only. Must be 9 digits or less
30	Balance Due	Required – Enter total amount due (subtract Amount Paid Item #29 from Total Charge Item #28. Must be 9 digits or less.
31	Signature of Physician or Supplier Including	Required – legal signature of provider or provider's authorized representative. Include date. Must be an

	Degrees or Credentials	actual signature or signature stamp or signature on file. Date format mm/dd/ccyy
32	Service Facility Location Information	Required if applicable - if different than Box #33.
32 a.	NPI Number	Must be 10 characters long, numeric only.
32 b.	Other ID Number	N/A
33	Billing Provider Info & Phone Number	Required – Enter the provider's or supplier's billing name, address, zip code and phone number.
33 a.	NPI Number	Required – except for Atypical providers. Must be 10 numeric digits.
33 b.	Other ID Number	Required – the two-digit qualifier identifying the non-NPI number followed by the ID number.