CLAIMS FILING INSTRUCTIONS

Effective as of

JANUARY 2015

CLAIMS FILING INSTRUCTIONS

Table of Contents

PROCEDURES FOR CLAIM SUBMISSION

Sunshine State Health Plan, Inc., hereafter referred to as Sunshine Health, is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. **Claims will be rejected or denied if not submitted correctly.** In general, Sunshine Health follows the CMS (Centers for Medicare & Medicaid Services) billing requirements. For questions regarding billing requirements, contact a Sunshine Health Provider Services Representative at 1-866-796-0530.

It is important that providers ensure Sunshine Health 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)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

We recommend that providers notify Sunshine Health 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.

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

- For EDI claims, rejections happen through one of our EDI clearinghouses if the appropriate information is not contained on the claim.
- For paper claims, rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP).

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

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

- All required fields are completed on the current industry standard CMS 1500 (HCFA), CMS 1450 (UB-04) paper claim form, or EDI electronic claim format.

  - All inpatient facilities are required to submit a **Present on Admission (POA) indicator** on all claims. Claims will be denied *(or rejected)* if the POA indicator is missing. Please reference the CMS billing guidelines regarding POA for more information and for excluded facility types.

- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service.
- All Diagnosis, Procedure, Modifier, and Location (Place of Service) Codes are valid for provider type/specialty billing.
- All Diagnosis, Procedure, and Revenue Codes are valid for the age and/or sex for the date of the service billed.
- All Diagnosis Codes are to their highest number of digits available (4^{th} or 5^{th} digit).
- Principle Diagnosis billed reflects an allowed Principle Diagnosis as defined in the current volume of ICD-9 CM, or ICD-10 CM for the date of service billed.
  - For a HCFA (CMS 1500) claim form, this criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary and that code is not valid as a primary diagnosis code, that line will be denied.
- National Drug Code (NDC) is billed in the appropriate fields on all claim forms as required by the state for pricing Physician Injectable Drugs and for Outpatient Hospitals and Renal Dialysis Centers per the Deficit Reduction Action (DRA) of 2005.
- **Member identification number is located in Box 1A of the paper HCFA 1500 form and Loop ID 2010 BA Segment NM109 of the 837p.**
- Member is eligible for services under Sunshine Health during the time period in which services were provided.
  - Appropriate authorizations were obtained for the services performed.
  - Note: Out-of-network providers require authorization for all services performed, except for emergent services, routine laboratory and routine radiology procedures.
- Provider has obtained and provided to Sunshine Health, their Florida Medicaid ID number.
- Medicare coverage or other third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.
- Required **Consent Forms** are included with the claim during the time of submission:
  - Consent forms can be located at the Florida Medicaid website at:

- Abortion Certification Form – http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/FORMS/HF_08_080902_Abortion_Certification_Blank.pdf
- Sterilization Consent Form – http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/FORMS/HF_08_080411_Sterilization__HHS-687_11-2006_English.pdf
- Hysterectomy Consent Form – http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/FORMS/HF_08_080902_Hysterectomy_Acknowledgement_071999.pdf
    - This form is required at time of prior authorization request and is not required at time of claim submission. *The form MUST be on file before claim will be paid.*

Claims Filing Deadlines

Original claims (first time claims) and corrected claims must be submitted to Sunshine Health within 180 calendar days from the date services were rendered or compensable items were provided. When Sunshine Health is the secondary payer, claims must be received within 180 calendar days from date of service or 90 calendar days of the final determination of the primary payer (whichever is later). Claims received outside of this timeframe will be denied for untimely submission.

All requests for reconsideration or claim disputes must be received within 90 days from the original date of notification of payment or denial. Prior processing will be upheld for provider claim requests for reconsideration or disputes received outside of the 90 days timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Mechanical or administrative delays or errors by Sunshine Health or the Florida Department for Medicaid Services.
- The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide their ID card or information.
    - The provider can substantiate that he continually pursued reimbursement from the patient until eligibility was discovered.

- The provider has not filed a claim for this member prior to the filing of the claim under review.

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

Corrected claims must be submitted within 180 days from the date of service. All claim requests for reconsiderations and claim disputes must be received within 90 days from the date of original notification of payment or denial was issued.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are five effective ways in which the provider can contact Sunshine Health.

1. Review the claim in question on the secure Provider Portal:
   - Participating providers, who have registered for access to the secure provider portal, can access claims to obtain claim status, submit claims or submit a corrected claim.
2. Contact a Sunshine Health Provider Service Representative at 1-866-796-0530:
   - Providers may inquire about claim status, payment amounts or denial reasons. A provider may also make a simple request for reconsideration by clearly explaining the reason the claim is not adjudicated correctly.
3. Submit an Adjusted or Corrected Claim to Sunshine Health :
   - Corrected claims must clearly indicate they are corrected in one of the following ways:
     - Submit corrected claim via the secure Provider Portal
       - Follow the instructions on the portal for submitting a correction
     - Submit corrected claim electronically via Clearinghouse

Corrected and/or Voided Claims are subject to Timely Claims Submission (i.e., Timely Filing) guidelines.

To submit a Corrected or Voided Claim electronically:

- For Institutional claims, provider must include the original Sunshine Health claim number for the claim adjusting or voiding in the REF*F8 (loop and segment) for any 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.
- For Professional claims, provider must have the Frequency Code marked appropriately as 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.

  - Mail original standard red and white corrected claim form along with the original EOP to:

    Sunshine Health
    Attn: Corrected Claim
    PO Box 3070
    Farmington MO 63640-4401

To submit a Corrected or Voided Claim via paper:
All corrected claims should be free of handwritten or stamped verbiage, and submitted on a standard red and white UB-04 or HCFA 1500 claim form.

- For Institutional claims, provider must include the original Sunshine Health claim number and bill frequency code per industry standards.
- Box 4 – Type of Bill: the third character represents the "Frequency Code"
    - Box 64 – Place the Claim number of the Prior Claim in Box 64
    - For Professional claims, provider must include the original Sunshine Health claim number and bill frequency code per industry standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

4. **Submit a "Request for Reconsideration" to Sunshine Health :**
    - **A request for reconsideration is a written communication (i.e. a letter)** from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
    - The request must include sufficient identifying information which includes, at a minimum, the patient name, patient ID number, date of service, total charges and provider name.
    - The documentation must also include a detailed description of the reason for the request.
    - Mail Requests for Reconsideration to:

      Sunshine Health
      Attn: Reconsideration
      PO Box 3070
      Farmington, MO 63640-3823
5. Submit a "Claim Dispute Form" to Sunshine Health :
    - A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
    - The Claim Dispute Form can be located on the provider website at SSHP Claim Adjustment Form.
    - To expedite processing of your dispute, please include the original Request for Reconsideration letter and the response.
    - Mail your "Claim Dispute Form" and all other attachments to:

      Sunshine Health
      Attn: Claim Dispute
      PO Box 3070
      Farmington, MO 63640-3823

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

Sunshine Health shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied status within 30 calendar days of receipt of the corrected claim, request for reconsideration or claim dispute.

Claim Payment

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

- 90% of clean claims will be processed within 30 business days of receipt
- 99% of clean claims will be processed within 90 business days of receipt

Adjusted claims, requests for reconsideration and disputed claims will be finalized to a paid or denied status 30 calendar days of receipt.

PROCEDURES FOR ELECTRONIC SUBMISSION

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

The benefits of billing electronically include:

- Reduction of overhead and administrative costs:
    - Eliminates the need for paper claim submission
    - Reduces claim re-work (adjustments)
- Receipt of clearinghouse reports as proof of claim receipt
- Faster transaction time for claims submitted electronically
- Validation of data elements on the claim format

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

Electronic Claim Submission

Providers are encouraged to participate in Sunshine Health's Electronic Claims/Encounter Filing Program through Centene. Sunshine Health (Centene) has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, Sunshine Health (Centene) has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

Sunshine Health
c/o Centene EDI Department
1-800-225-2573, extension 25525
Or by e-mail at: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who 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.

Electronic Secondary Claims

Sunshine Health has the ability to receive coordination of benefit (COB or Secondary) claims electronically. The field requirements for successful electronic COB submission are below (5010 Format):

COB Field Name **The below should come from the primary payer's Explanation of Payment**	**837I - Institutional EDI Segment and Loop**	**837P - Professional EDI Segment and Loop**
COB Paid Amount	If 2320/AMT01=**D**, MAP AMT02 or 2430/SVD02	If 2320/AMT01=**D**, MAP AMT02 or 2430/SVD02
COB Total Non-Covered Amount	If 2320/AMT01=**A8**, map AMT02	If 2320/AMT01=**A8**, map AMT02
COB Remaining Patient Liability	If 2300/CAS01 = PR, map CAS03 Note: Segment can have 6 occurrences. Loop2320/AMT01=**EAF**, map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR	If 2320/AMT01=**EAF**, map AMT02
COB Patient Paid Amount		If 2320/AMT01 = **F5**, map AMT02
COB Patient Paid Amount Estimated	If 2300/AMT01=**F3**, map AMT02	
Total Claim Before Taxes Amount	If 2400/AMT01 = **N8**, map AMT02	If 2320/AMT01 = **T**, map AMT02
COB Claim Adjudication Date	IF 2330B/DTP01 = 573, map DTP03	IF 2330B/DTP01 = 573, map DTP03
COB Claim Adjustment Indicator	IF 2330B/REF01 = T4, map REF02	IF 2330B/REF01 = T4, map REF02 with a Y

Specific Data Record Requirements

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

Electronic Claim Flow Description & Important General Information

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

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

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

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

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

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

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to clearly mark your claim as a corrected claim per the instructions above.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Sunshine Health must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. **Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Sunshine Health.** In these cases, the claim must be corrected and re-submitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately. **Our companion guides to billing electronically are available on our website at www.sunshinehealth.com. See section on electronic claim filing for more details.**

Exclusions

Excluded Claim Categories - Excluded from EDI Submission Options - Must be Filed Paper - Applies to Inpatient and Outpatient Claim Types
Claim records requiring supportive documentation or attachments (i.e., consent forms) Note: **COB claims can be filed electronically**, but if they are not, the primary payer EOB must be submitted with the paper claim.
Medical records to support billing miscellaneous codes
Claim for services that are reimbursed based on purchase price (e.g. custom, DME, prosthetics) Provider is required to submit the invoice with the claim.
Claim for services requiring clinical review (e.g. complicated or unusual procedure) Provider is required to submit medical records with the claim.
Claim for services needing documentation and requiring Certificate of Medical Necessity Oxygen, Motorized Wheelchairs

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Clearinghouses Submitting Directly to Sunshine State Health Plan	Emdeon Availity Gateway EDI Medavant SSI
Sunshine State Health Plan Payer ID	68069NOTE: Please reference the vendor provider manuals at www.sunshinehealth.com for their individual payer ID's.
General EDI Questions:	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
Claims Transmission Report Questions:	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
Remittance Advice Questions:	Contact Sunshine State Health Plan Provider Services at 1-866-796-0530 or the secure Provider Portal at www.sunshinehealth.com.
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Services in writing at: Sunshine State Health Plan 1301 International Pkwy. 4th Floor Sunrise, FL 33323 Or via Fax to: 1-866-614-4955

Important Steps to a Successful Submission of EDI Claims

1. Select clearinghouse to utilize.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Sunshine Health.
3. Inquire with the clearinghouse what data records are required.
4. Verify with Provider Relations at Sunshine Health that the provider is set up in the Sunshine Health system before submitting EDI claims.
5. You will receive two reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Sunshine Health and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Sunshine Health. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted correct and resubmit.
6. MOST importantly, all claims must be submitted with provider identifying numbers. See the CMS 1500 (8/05) and UB-04 1450 claim form instructions and claim forms for details. NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the fields are empty.

EFT and ERA

Sunshine Health 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:

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

For more information on our EFT and ERA services, please visit our website at www.sunshinehealth.com or contact Provider Services at 1-866-796-0530.

PROCEDURES FOR ONLINE CLAIM SUBMISSION

For providers who have internet access and choose not to submit claims via EDI or paper, Sunshine Health has made it easy and convenient to submit claims directly to us on our secure provider portal at www.sunshinehealth.com.

You must request access to our secure site by registering for a user name and password and you must select the Claims Role Access module. To register, please go directly to www.sunshinehealth.com. If you have technical support questions, please contact Provider Services at 1-866-796-0530.

Once you have access to the secure portal you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims.

PAPER CLAIM SUBMISSION REQUIREMENTS

Submit claims to Sunshine Health at the following address:

First Time Claims, Corrected Claims and Requests for Reconsiderations:
Sunshine Health
Claim Processing Department
P. O. Box 3070
Farmington, MO 63640-3823

Claim Dispute Forms:
Sunshine Health
Attn: Claim Disputes
P. O. Box 3070
Farmington, MO 63640-3823

Sunshine Health encourages all providers to submit claims electronically. Our companion guides to billing electronically are available on our website at www.sunshinehealth.com.

CLAIM FORM REQUIREMENTS

Claim Forms

Sunshine Health only accepts the CMS 1500 (8/05) 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 (8/05) form and institutional providers complete the CMS 1450 (UB-04) claim form. Sunshine Health does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. It is preferred that all paper claim forms be typed or printed and

in the original red and white version to ensure clean acceptance and processing. If the form is hand-written, the information must be clear, must be written in black or blue ink and all data must be within the pre-determined lines/boxes on the form. If you have questions regarding what type of form to complete, contact Sunshine Health Provider Services at 1-866-796-0530.

Coding of Claims/Billing Codes

Sunshine Health requires claims to be submitted using codes from the current version of ICD-9-CM, ICD-10, 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 inappropriate for the age or sex of the member
- Diagnosis code missing the 4th or 5th digit as appropriate
- 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 Sunshine Health.

To ensure claims are processed in accordance with the copayment and coinsurance guidelines as outlined by the Department, **it is important to bill appropriate SM and SN modifiers to indicate Second Opinion and Third Opinion**, respectively. Members are not responsible for copayments when obtaining a second or third opinion for services.

For more information regarding billing codes, coding, and code auditing and editing contact a Sunshine Health Provider Services Representative at 1-866-796-0530.

Claims Mailing Instructions

Submit claims to Sunshine Health at the following address:

First Time Claims, Corrected Claims and Requests for Reconsiderations:
Sunshine Health
Claim Processing Department
P. O. Box 3070
Farmington, MO 63640-3823

Claim Dispute Forms:
Sunshine Health
Attn: Claim Disputes
P. O. Box 3070
Farmington, MO 63640-3823

Sunshine Health encourages all providers to submit claims electronically. Our companion guides to billing electronically are available on our website at www.sunshinehealth.com.

Code Auditing and Editing

Sunshine Health uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes. Claims billed in a manner that does not adhere to the standards of the code editing software will be denied.

The code editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

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

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

Unbundling of Services – Identifies Services That Have Been Unbundled

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

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

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

Bilateral Surgery – Identical Procedures Performed on Bilateral Anatomical Sites during Same Operative Session:

Example:

Code	Description	Status
69436 DOS=01/01/10	Tympanostomy	Disallow
69436 50 DOS=01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Allow

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

Duplicate Services – Submission of Same Procedure More than Once on Same Date of Service That Cannot Be or Are Normally Not Performed More Than Once on Same Day:

Example: Excluding a Duplicate CPT

Code	Description	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation:

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.

- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services (E/M) – Submission of E/M Service Either Within a Global Surgery Period or on the Same Date of Service as Another E/M Service:

Global Surgery:

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

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

Example: Global Surgery Period

Code	Description	Status
27447 DOS=05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 DOS=06/02/09	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face w/patient &/or family.	Disallow

Explanation:

- Procedure code 27447 has a global surgery period of 90 days.
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

Example: E/M with Minor Surgical Procedures

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

Explanation:

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

Same Date of Service

One evaluation and management service is recommended for reporting on a single date of service.

Example: Same Date of Service

Code	Description	Status
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with patient and/or family.	Allow
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or	Disallow

	agencies are provided consistent with nature of problem(s) and patient's/family's needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face-to-face with patient/family.	

Explanation:

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.
- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation

NOTE:

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

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

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

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

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

Modifiers – Codes Added to the Main Procedure Code to Indicate the Service Has Been Altered by a Specific Circumstance:

<u>Modifier -26 (professional component)</u>

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

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.

- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier -26 appended.

Example:

Code	Description	Status
78278 POS=Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 POS=Inpatient	Acute gastrointestinal blood loss imaging	Allow

Explanation:

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

Modifier -80, -81, -82, and -AS (assistant surgeon)

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

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

Example:

Code	Description	Status
42820-81	Tonsillectomy and adenoidectomy; under age 12	Disallow

Explanation:

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

CPT® Category II Codes

CPT Category II Codes are supplemental 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.

Code Editing Assistant

A web-based code auditing reference tool designed to "mirror" how Sunshine Health code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers via the secure provider portal. This allows Sunshine Health to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims. You can access the tool in the Claims Module by clicking "Claim Auditing Tool".

This tool offers many benefits:

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services *before* claims are submitted
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

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

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

REJECTIONS VS. DENIALS

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

REJECTION:

A **REJECTION** is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.sunshinehealth.com. A list of common upfront rejections can be found listed below and a more comprehensive list with explanations can be located in Appendix 1. Rejections will not enter our claims adjudication system, so there will be no Explanation

of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

DENIAL

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

APPENDIX

APPENDIX I: COMMON CAUSES OF UPFRONT REJECTIONS

- **Unreadable Information -** The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or hand written information is not legible
- **Member Date of Birth** is missing
- **Member Name or Identification Number** is missing
- **Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number** is missing
- **Attending Provider** information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22 or 72 or missing from box 48 on the paper UB claim form
- **Date of Service** is not prior to the received date of the claim (future date of service)
- **Date of Service or Date Span** is missing from required fields
    - Example: "Statement From" or “Service From" dates
- **Type of Bill** is invalid
- **Diagnosis Code** is missing, invalid, or incomplete
- **Service Line Detail** is missing
- **Date of Service** is prior to member’s effective date
- **Admission Type** is missing (Inpatient Facility Claims – UB-04, field 14)
- **Patient Status** is missing (Inpatient Facility Claims – UB-04, field 17)
- **Occurrence Code/Date** is missing or invalid
- **Revenue Code** is missing or invalid
- **CPT/Procedure Code** is missing or invalid
- **Incorrect Form Type** used

APPENDIX II: COMMON CAUSES OF CLAIMS PROCESSING DELAYS AND DENIALS

- **Diagnosis Code** is missing the 4th or 5th digit
- **Procedure** or **Modifier Codes** entered are invalid or missing
    - **This includes GN, GO or GP modifier for therapy services**
- **DRG** code is missing or invalid
- **Explanation of Benefits (EOB)** from the primary insurer is missing or incomplete
- **Third Party Liability** (TPL) information is missing or incomplete
- **Member ID** is invalid
- **Place of Service Code** is invalid
- **Provider TIN and NPI** does not match
- **Revenue Code** is invalid
- **Dates of Service** span do not match the listed days/units
- **Physician Signature** is missing
- **Tax Identification Number (TIN)** is invalid
- **NDC Code** missing for drug codes
- **EPSDT/Referral Code missing**

APPENDIX III: COMMON EOP DENIAL CODES AND DESCRIPTIONS

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

CODE	DESCRIPTION
07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX
09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX
18	DENY: DUPLICATE CLAIM/SERVICE
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
46	DENY: THIS SERVICE IS NOT COVERED
50	DENY:NOT A MCO COVERED BENEFIT
86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
99	DENY:MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT
1K	DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT
3D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT
4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT
9M	DENY: THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS
A1	DENY: AUTHORIZATION NOT ON FILE
BG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT
BI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
CF	DENY: WAITING FOR CONSENT FORM
DS	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS
DW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT
DX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE.
EC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
HQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY WITH CONSENT FORM
IM	DENY: RESUBMIT WITH CORRECT MODIFIER
L6	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.
LO	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.
MG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT
MO	MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE.
MQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT
NT	DENY:PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT
U1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
VI	GLOBAL FEE PAID
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x4	PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBERS GENDER
x5	PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE
x6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
x7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
xa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
xb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
xc	PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID
xd	PROCEDURE CODE APPENDED WITH BILATERAL 50 MODIFIER
xe	PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE
xf	MAXIMUM ALLOWANCE EXCEEDED
xh	PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
xp	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
xq	PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
Y6	DENY:INSUFFICIENT INFO FOR PROCESSING,RESUBMIT W/PRIME'S ORIGINAL EOB
ye	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
ZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY

APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

CMS-1500 (8/05) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (8/05) form field 24A-G:

- Anesthesia duration
- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number–Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council–Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products

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

7 Anesthesia information

ZZ Narrative description of unspecified/miscellaneous/unlisted codes

N4 National Drug Codes (NDC)
The following qualifiers are to be used when reporting NDC units:
F2 International Unit
GR Gram
ML Milliliter
UN Unit

OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)

VP Vendor Product Number- Health Industry Business Communications Council (HIBCC) Labeling Standard

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 supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN 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 a single shaded claim line **IF** the information is related to the un-shaded claim line item it is entered on. When entering more than one supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three blank spaces and then the next qualifier and number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code.

Examples:

Anesthesia

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. #
7Begin 1315 End 1445 Time 90 minutes											
										NPI	

Unlisted, Non-specific, or Miscellaneous CPT or HCPC Code

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. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached											
										NPI	

Vendor Product Number- HIBCC

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. #
VPA123ABC7D9E1F											
										NPI	

Product Number Health Care Uniform Code Council – GTIN

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. #
OZ01234567891112											
										NPI	

APPENDIX V: 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.

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

Code	Description
01	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; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date
75	Invalid units of service

APPENDIX VI: 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 Type	Field
CMS 1500 (08/05)	24 A (shaded claim line)
UB 04	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
UN – Unit

APPENDIX VII: CLAIMS FORM INSTRUCTIONS

BILLING GUIDE for a CMS-1500 and CMS UB-04

Appendix

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

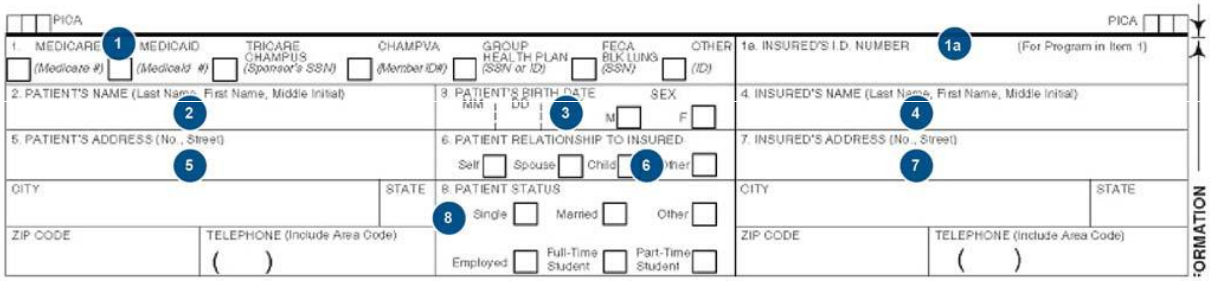
Completing a CMS 1500 Form

CMS 1500 (8/05) Claim Form Instructions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

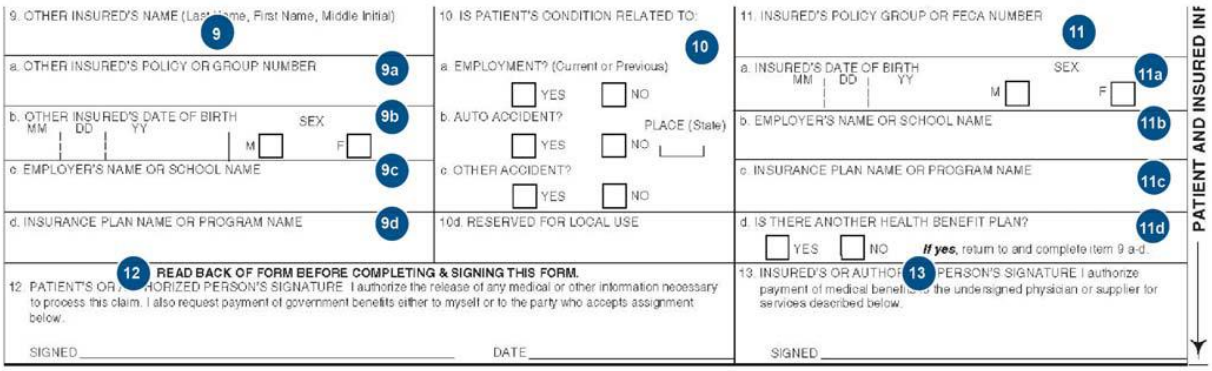
CMS 1500 Claim Form



Field #	Field Description	Instructions and Comments	Required or Conditional
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select "D", other	Not Required
1a	**INSURED I.D NUMBER**	The 10-digit Medicaid identification number on the member's SUNSHINE HEALTH I.D. card.	R
2	**PATIENT'S NAME (Last Name, First Name, Middle Initial)**	Enter the patient's name as it appears on the member's SUNSHINE HEALTH I.D. card. Do not use nicknames.	R
3	**PATIENT'S BIRTH DATE / SEX**	Enter the patient's 8-digit date of (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 SUNSHINE HEALTH I.D. card.	R

Field #	Field Description	Instructions and Comments	Required or Conditional
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 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e.(803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1	R
6	**PATIENT'S RELATION TO INSURED**	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 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e.(803)551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	Not Required
8	**PATIENT STATUS**		Not Required

CMS 1500 Claim Form

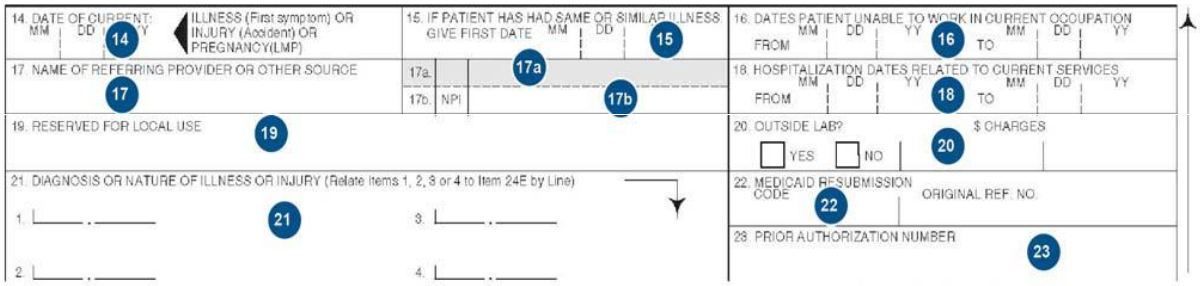


Field #	Field Description	Instructions and Comments	Required or Conditional
9	**OTHER INSURED'S NAME (Last Name, First Name, Middle Initial**	Refers to someone other than the patient. **REQUIRED** if patient is covered by another insurance plan. Enter the complete name of the insured. **NOTE:** COB claims that require attached EOBs must be submitted on paper.	C
9a	***OTHER INSURED'S POLICY OR GROUP NUMBER**	**REQUIRED** if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	**OTHER INSURED'S BIRTH DATE / SEX**	**REQUIRED** if # 9 is completed. Enter the 8-digit date of birth (MM|DD|YYYY) and mark the appropriate box to indicate sex/gender M = male F = female for the person listed in box 9.	C
9c	**EMPLOYER'S NAME OR SCHOOL NAME**	Enter the name of employer or school for the person listed in box 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1	C
9d	**INSURANCE PLAN NAME OR PROGRAM NAME**	**REQUIRED** if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, 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.	R

Field #	Field Description	Instructions and Comments	Required or Conditional
10d	**RESERVED FOR LOCAL USE**		Not Required
11	**INSURED'S POLICY GROUP OR FECA NUMBER**	**REQUIRED** when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	**INSURED'S DATE OF BIRTH / SEX**	Same as field 3.	C
11b	**EMPLOYER'S NAME OR SCHOOL NAME**	**REQUIRED** if Employment is marked Yes in box 10a.	C
11c	**INSURANCE PLAN NAME OR PROGRAM NAME**	Enter name of the insurance Health Plan or program.	C
11d	**IS THERE ANOTHER HEALTH BENEFIT PLAN**	Mark Yes or No. If Yes, complete # 9a-d and #11c	R

Field #	Field Description	Instructions and Comments	Required or Conditional
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 their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Required
13	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**		Not Required

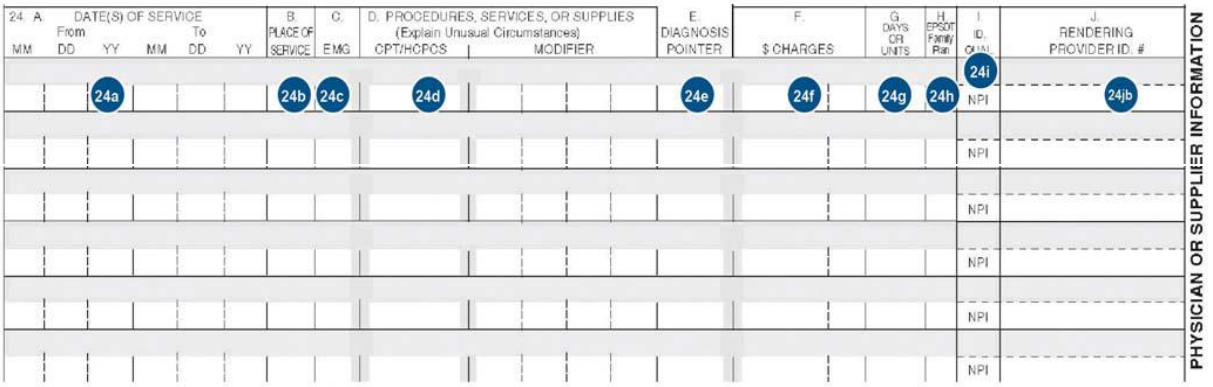
CMS 1500 Claim Form



Field #	Field Description	Instructions and Comments	Required or Conditional
14	**DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)**	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date reflecting the first date of onset for the: ➢ Present illness ➢ Injury ➢ LMP (last menstrual period) if pregnant	C
15	**IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE**		Not Required
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**		Not Required
17	**NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	C

Field #	Field Description	Instructions and Comments	Required or Conditional
17a	**ID NUMBER OF REFERRING PHYSICIAN**	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	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**		Not Required
19	**RESERVED FOR LOCAL USE**		Not Required
20	**OUTSIDE LAB / CHARGES**		Not Required
21	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)**	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9-CM Volume 1 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or“5”. "E" codes are NOT acceptable as a primary diagnosis. **NOTE:** Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	**MEDICAID RESUBMISSION CODE / ORIGINAL REF.NO.**	For re-submissions, adjustments, and corrected claims enter the claim number of the original claim.	C
23	**PRIOR AUTHORIZATION NUMBER/CLIA NUMBER**	CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.	C

CMS 1500 Claim Form



Field #	Field Description	Instructions and Comments	Required or Conditional
24A-J General Information	**Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and unshaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24J. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.** ➢ **The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, Provider Medicaid Number qualifier, and Provider Medicaid Number.** ➢ **Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below and in Appendix 4 for information on how to complete.** ➢ **The un-shaded area of a claim line is for the entry of claim line item detail.**		
24A-G Shaded	**SUPPLEMENTAL INFORMATION**	The shaded top portion of each service claim line is used to report supplemental information for: ➢ NDC ➢ Anesthesia Start/Stop time & duration ➢ Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. ➢ HIBCC or GTIN number/code. For detailed instructions and qualifiers refer to Appendix 4 of this manual	C
24A Un-shaded	**DATE(S) 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 within a date span, enter the date span in the “From” and “To” fields. The count listed in field 24G for the service must	R

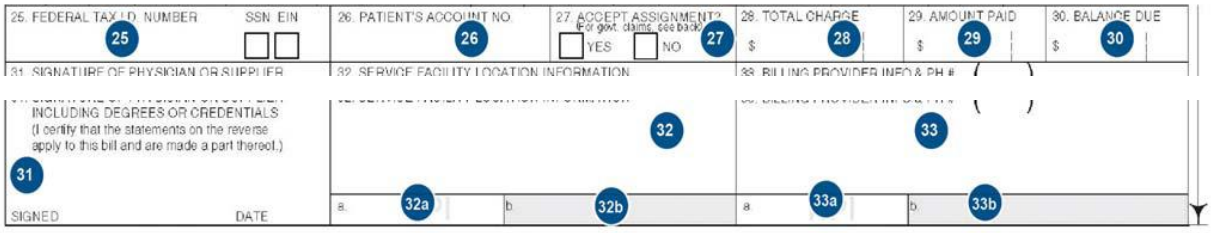
		correspond with the date span entered.	
24B Un-shaded	**PLACE OF SERVICE**	Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website or the following link: http://www.cms.hhs.gov/PlaceofServiceCodes/ Downloads/placeofservice.pdf	R
24C Un-shaded	**EMG**	Enter Y (Yes) or N (No) to indicate if the service was an emergency	R

Field #	Field Description	Instructions and Comments	Required or Conditional
24D Un-shaded	**PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER**	Enter the 5-digit CPT or HCPC code and 2-character modifier– - if applicable. Only one CPT or HCPC and up to 4 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. 53 54 55 62 66 76 78 79 80 81 82 99 AA AD FP LL LT NU QK QS QX QY QZ RR RT SB TC UE	R
24E Un-shaded	**DIAGNOSIS CODE**	Enter the numeric single digit diagnosis pointer (1,2,3,4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9 codes for the date of service or the claim will be rejected/denied	R
24F Un-shaded	**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 8 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 Un-shaded	**DAYS OR UNITS**	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.	R

24H Shaded	**CHCUP Family Planning**	Enter "Y" if service is a result of a CHCUP referral. Enter "N" if qualifier is equal to U	R
24H Un-shaded	**CHCUP Family Planning**	Enter the appropriate qualifier for CHCUP visit ***V Patient Refused Referral*** ***U Patient Not Referred*** ***2 Under Treatment*** *(For referred diagnostic or corrective health problem)* ***T New Services Requested*** *(Patient Referred to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during a Child Health Check-Up, not including dental referrals)*	R
24I Shaded	**ID QUALIFIER**	Use ZZ qualifier for Taxonomy	C

Field #	Field Description	Instructions and Comments	Required or Conditional
24Ja Shaded	**Non-NPI PROVIDER ID#**	**Enter as designated below the Medicaid ID number or taxonomy code.** ➢ *Typical Providers*: Enter the Provider taxonomy code or Medicaid Provider ID number that corresponds to the qualifier entered in 24Ishaded. Use ZZ qualifier for taxonomy code. ➢ *Atypical Providers*: Enter the 6-digit Medicaid Provider ID number	R
24Jb Un-shaded	**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-character NPI ID may be entered.	R

CMS 1500 Claim Form



Field #	Field Description	Instructions and Comments	Required or Conditional
25	**FEDERAL TAX I.D. NUMBER SSN/EIN**	Enter the provider or supplier 9-digit Federal Tax ID number and mark the	R

		box labeled EIN.	
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 Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	R
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 8 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

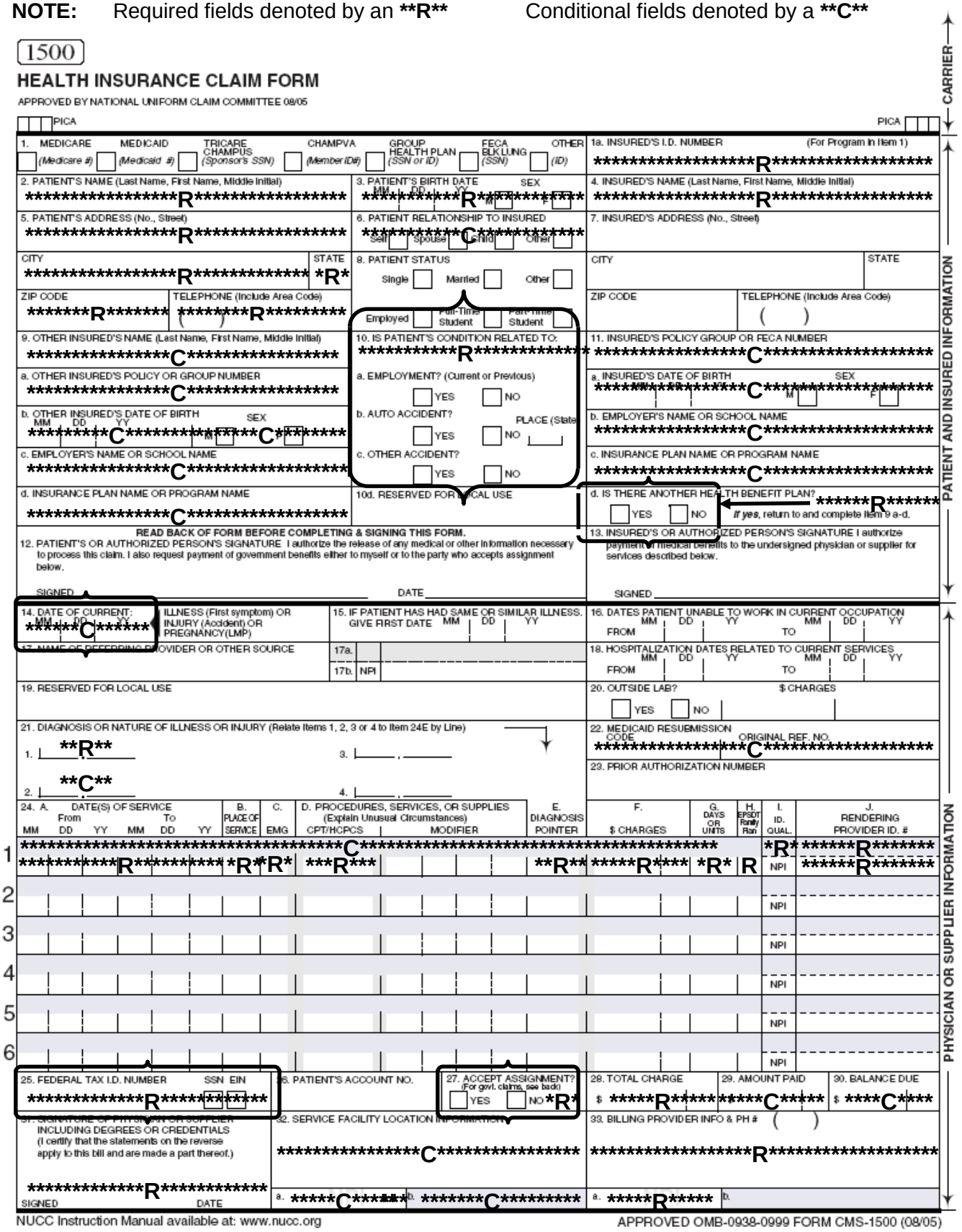
Field #	Field Description	Instructions and Comments	Required or Conditional
29	**AMOUNT PAID**	**REQUIRED** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing SUNSHINE HEALTH . Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	**BALANCE DUE**	**REQUIRED** when #29 is completed Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
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. Note: does not exist in the electronic 837P.	Required
		REQUIRED if the location where services were rendered is different	

32	**SERVICE FACILITY LOCATION INFORMATION**	**from the billing address listed in field 33.** Enter the name and physical location. (P.O. Box #'s are **not** acceptable here**.)** ➢ 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	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.	C
32b	**OTHER PROVIDER ID**	**REQUIRED if the location where services were rendered is different from the billing address listed in field 33.** ➢ *Typical Providers* Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). ➢ *Atypical Providers* Enter the 2-character qualifier 1D followed by the 6-character Medicaid Provider ID number (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.(803)551414).	R
	GROUP BILLING NPI	**Typical Providers ONLY: REQUIRED if the location where services were**	

33a		**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 Medicaid ID number or taxonomy code** ➢ *Typical Providers*: Enter the Provider taxonomy code. Use ZZ qualifier. ➢ *Atypical Providers***:** Enter the 6-digit Medicaid Provider ID number.	R

Appendix

NOTE: Required fields denoted by an ****R**** Conditional fields denoted by a ****C****



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. **R**

2. **C**

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

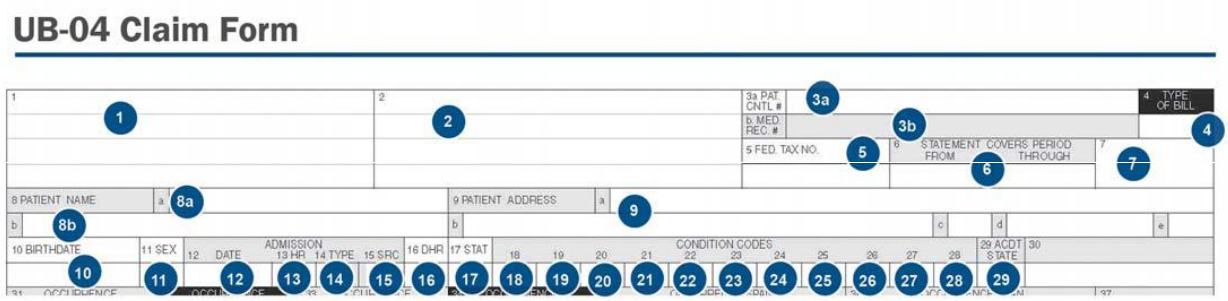
NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UB-04/CMS 1450 (8/05) Claim Form Instructions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.



Field #	Field Description	Instructions and 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 code (include hyphen) 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 NO.**	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 3-digit 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 billing sequence.	R
5	**FED. TAX NO.**	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R

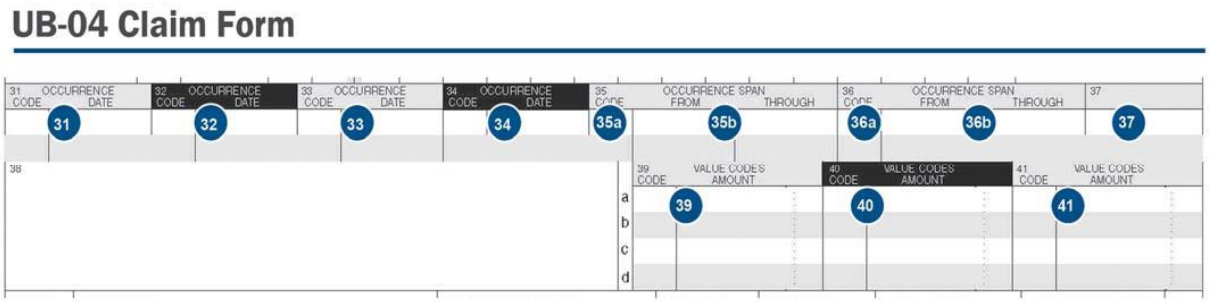
6	**STATEMENT COVERS PERIOD FROM/THROUGH**	Enter begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis 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
8 a-b	**PATIENT NAME**	**8a** – Enter the patient's 10-digit Medicaid identification number on the member's SUNSHINE HEALTH I.D. card	Not Required
		8b – Enter the patient's last name, first name, and middle initial as it appears on the SUNSHINE HEALTH 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 a-e	**PATIENT ADDRESS**	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.	R

13	**ADMISSION HOUR**	Enter the time using 2-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 and outpatient services (TOB 11X, 118X, 21X, 41X). Enter the 1-digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	C
15	**ADMISSION SOURCE**	Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes: 1 Physician Referral 2 Clinic Referral 4 Transfer from a hospital 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law enforcement 9 Information not available	R

<table>
<tr><td>16</td><td>DISCHARGE HOUR</td><td>Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge.

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</td><td>Not Required</td></tr>
<tr><td>17</td><td>PATIENT STATUS</td><td>REQUIRED for inpatient 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:
Status Description
01 Discharged to home or self-care
02 Transferred to another short-term general hospital
03 Transferred to a SNF
04 Transferred to an ICF
05 Transferred to another type of institution
06 Discharged home to care of home health
07 Left against medical advice
08 Discharged home under the care of a Home IV provider
20 Expired
30 Still patient or expected to return for outpatient services
31 Still patient – SNF administrative days
32 Still patient – ICF administrative days
62 Discharged/Transferred to an IRF, distinct rehabilitation unit of a hospital
65 Discharged/Transferred to a psychiatric hospital or distinct psychiatric unit of a hospital</td><td>C</td></tr>
<tr><td>18-28</td><td>CONDITION CODES</td><td>REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing.</td><td>C</td></tr>
</table>

		Each field (18-24) allows entry of a 2-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 Uniform Billing Manual.	
29	**ACCIDENT STATE**		Not Required
30	**(UNLABELED FIELD)**	Not Used	Not Required

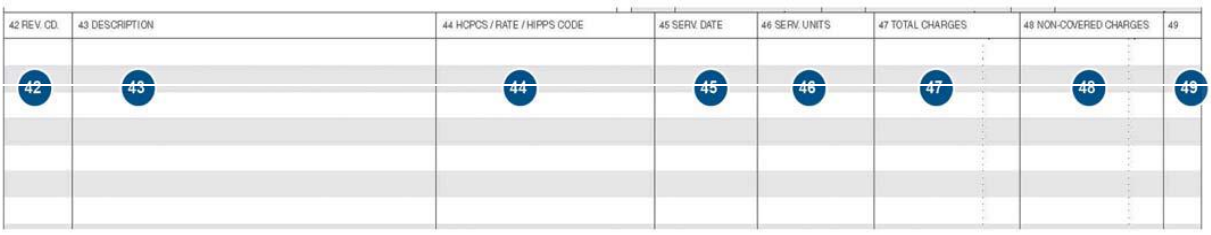


31-34 a-b	**OCCURRENCE CODE and OCCURENCE DATE**	**Occurrence Code: REQUIRED** when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence(numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 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 assoc.	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 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).	C

		For a list of codes and additional instructions refer to the NUBC UB-04 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 MMDDYYYY format.	
37	**(UNLABELED FIELD)**	**REQUIRED** for re-submissions or adjustments. Enter the 12-character DCN (Document Control Number) 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:** Re - submissions may **NOT** currently be submitted via EDI.	C
38	**RESPONSIBLE PARTY NAME AND ADDRESS**		Not Required
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 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 8 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.	C

Appendix

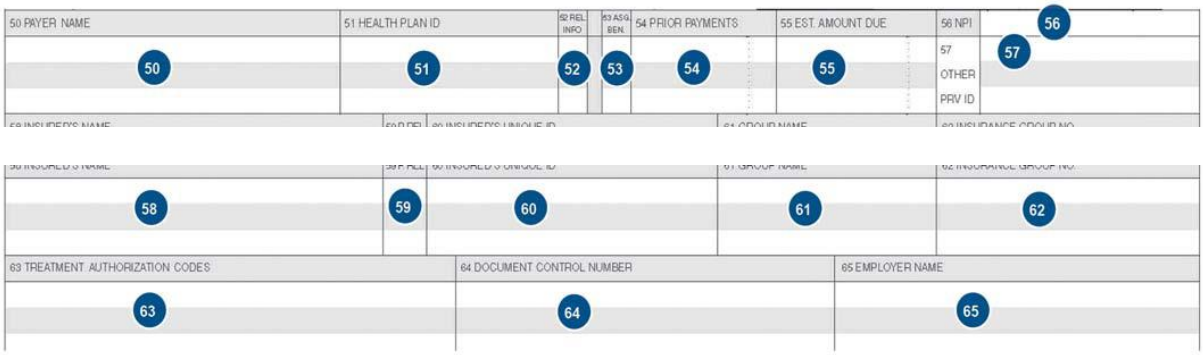
UB-04 Claim Form



General Information Fields 42-47	Service Line Detail	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 4 digit 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 a brief description that corresponds to the revenue code entered in the service line of field 42.	R
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”).	R
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 modifier(s) do not use a 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 listing of revenue codes and instructions.	C

		The following revenue codes/revenue code ranges must always have an accompanying CPT/HCPC. 300-302 329-330 360-361 610-612 304-307 333 363-366 615-616 309-312 340-342 368-369 618-619 314 349-352 400-404 634-636 319-324 359 490-499 923	
45 Line 1-22	**SERVICE DATE**	**REQUIRED** on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims	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.	R
47 Line 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 Line 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

UB-04 Claim Form

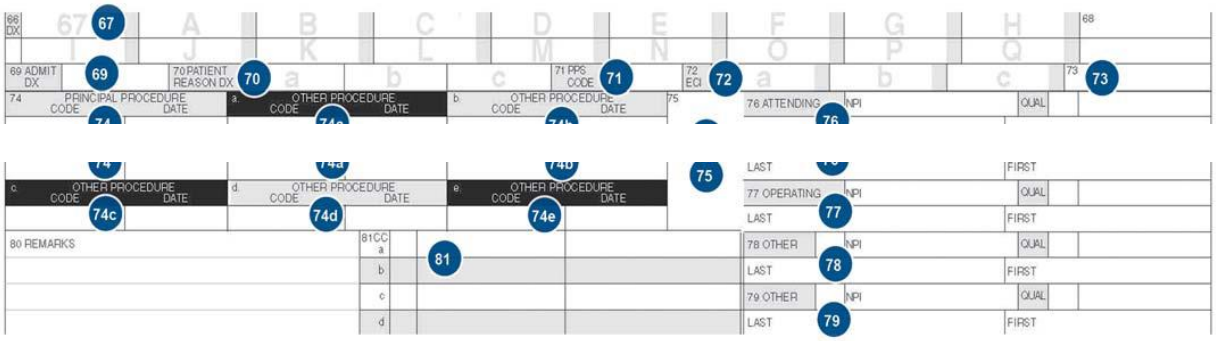


50 A-C	**PAYER**	Enter the **name** for each Payer reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C,	R

		tertiary.	
51 A-C	**HEALTH PLAN IDENTIFICATION NUMBER**		Not Required
52 A-C	**REL. INFO**	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 authorizing payment by the payer directly to the provider for services	R
54	**PRIOR PAYMENTS**	Enter the amount received from the primary payer on the appropriate line when Medicaid/ SUNSHINE HEALTH is listed as secondary or tertiary.	C
55	**EST. AMOUNT DUE**		Not Required
56	**NATIONAL PROVIDER IDENTIFIER or PROVIDER ID**	**Required:** Enter provider’s 10-character NPI ID.	R
57	**OTHER PROVIDER ID**	Enter the qualifier “1D” followed by your 6-digit Medicaid Provider ID number.	Not Required
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/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance /Medicaid ID in the order of liability listed in field 50.	R
61	**GROUP NAME**		Not Required
62	**INSURANCE GROUP NO.**		Not Required
63	**TREATMENT AUTHORIZATION CODES**		Not Required
64	**DOCUMENT CONTROL**	Enter the original claim number of the paid SUNSHINE HEALTH claim when submitting a	C

	NUMBER	replacement or void on the corresponding A, B, C line reflecting SUNSHINE HEALTH 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).	
65	**EMPLOYER NAME**		Not Required
66	**DX**		Not Required

UB-04 Claim Form



67	**PRINCIPAL DIAGNOSIS CODE**	Enter the principal/primary diagnosis or condition (the condition established after study that is chiefly responsible for causing the visit) using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or"5". "E" and most "V" codes are NOT acceptable as a primary diagnosis. **NOTE:** Claims missing or with invalid diagnosis codes will be denied for payment.	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- CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or"5". "E" and most "V" codes are NOT acceptable as a primary diagnosis. **NOTE:** Claims with incomplete or invalid diagnosis codes will be denied for payment.	C

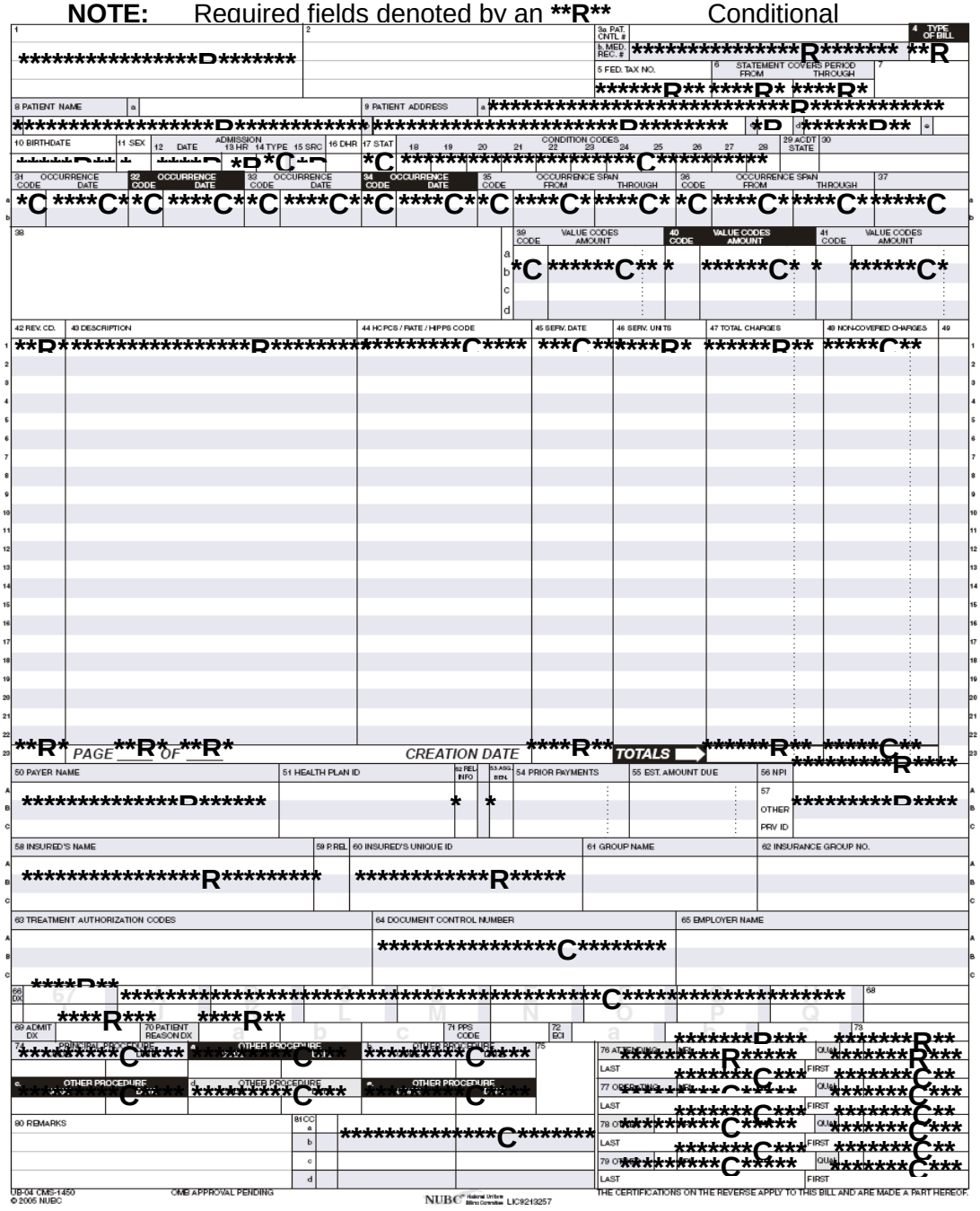
68	**(UNLABELED)**	Not Used	Not Required
69	**ADMITTING DIAGNOSIS CODE**	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or"5". "E" codes and most "V" are NOT acceptable as a primary diagnosis. **NOTE:** Claims missing or with invalid diagnosis codes will be denied for payment	R
70 a,b,c	**PATIENT REASON CODE**	Enter the ICD-9-CM code that reflects the patient's reason for visit at the time of outpatient registration. 70a **requires** entry, 70b-70c are conditional. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or"5". "E" codes and most "V" are NOT acceptable as a primary diagnosis. **NOTE:** Claims missing or with invalid diagnosis codes will be denied for payment.	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**	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code that identifies the principal/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). **REQUIRED** for EDI Submissions.	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 procedure code(s) that identify significant a procedure(s) performed	C

		other than the principal/primary procedure. Up to 5 ICD-9 procedure codes may be entered. 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).	
75	**(UNLABELED)**		Not Required
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 # ZZ – 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: **NPI:** Enter the operating 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 # ZZ – Taxonomy Code **LAST:** Enter the operating physician's last name **FIRST:** Enter the operating physician's first name.	C

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 # 1G – Provider UPIN G2 – Provider Commercial # **LAST:** Enter the other physician's last name. **FIRST:** Enter the other physician's first name.	C
80	**REMARKS**		Not Required
81	**CC**	**A:** Taxonomy of billing provider. Use ZZ qualifier	C

Appendix

NOTE: Required fields denoted by an **R** Conditional



Appendix VIII: Billing Tips and Reminders

Modifiers:

Appropriate Use of – 25, 26, TC and 50

- *25 Modifier should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day of another procedure e.g. Well-Child and sick visit performed on the same day by the same physician *Note: 25 modifier is not appended to non E&M procedure codes, e.g. lab*

26 Modifier – should never be applied to an office visit CPT code

- *Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes*
- *Inappropriate use may result in a claim denial/rejection*

TC Modifier – used to indicate the technical component of a test or study is performed

50 Modifier – indicates a procedure performed on a bilateral anatomical site

- *Procedure must be billed on a single claim line with the 50 modifier and quantity of one (1)*
- *RT and LT modifiers and quantities greater than one (1) should not be billed when using modifier 50*

Multi-page claims

- *Do not total each page of the claim – the last page of the claim should contain the total*
  - *CMS 1500 Claim Form – Block 28 of the last page should contain the total*
  - *UB-04 Claim Form – Line 23, Block 47 should contain the total*
  - *The pages leading up to the last page of a multi-page claim should contain the word "continued" or "cont."*
  - *Totaling each page will result in separate claims that may incorrectly reimburse*

Claim Signature – Paper Claims

- *CMS 1500 Form – Block 31 must contain a signature for paper claims (physician, authorized representative or supplier); Note: The signature in Block 31 must match the NPI billed in Block 24J of the claim form*

- *Signature on file is not accepted*
- *Accepted signatures are: hand-written, a stamp, or computer generated*

Diagnosis Codes

- *Must code out to the highest number of digits available – 4th or 5th as applicable*

National Drug Code (NDC) – must be included on the CMS 1500 and UB-04 Claim Forms

- For Paper, use Form Locator 43 of the CMS 1450 and the red shaded detail of 24A on the CMS 1500 line detail. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.
- For Electronic submissions, which is highly recommended and will enhance claim reporting/adjudication processes, report in the LIN segment of Loop ID-2410

Anesthesia – bill total time units in Block 24G of the CMS 1500 Claim Form

- *Failure to bill total time units may result in incorrect reimbursement or claim denial*
- *Start and Stop times must appear in the shaded area of Block 24A of the CMS 1500 Claim Form*

Ambulatory Surgery Centers (ASC)

- *Ambulatory Surgery Centers must submit charges using the UB-04 claim form*
    - *CMS 1500 Claim Form is used to submit the professional services, not facility charges.*

CHCUP – Child Health Check Up

- The CHCUP Referral Indicators are required for all claim submissions (paper and electronic) in order to be reimbursed for a CHCUP. The indicators are required for claims billed with Evaluation & Management (E&M) services for procedure codes 99381 - 99385 and 99391 - 99395.
- The referral indicator is required on the E&M service line only.

- The EOP will reflect the following denial code if required information is missing or invalid, EXRC DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING.

CMS – 1500 (Paper)

24H - Shaded	**CHCUP Family Planning**	Enter "Y" if service is a result of a CHCUP referral. Enter "N" if qualifier is equal to "U".
24H – Un-shaded	**CHCUP Family Planning**	Enter the appropriate qualifier for CHCUP E&M visit **V Patient Refused Referral** **U Patient Not Referred** **2 Under Treatment** (For referred diagnostic or corrective health problem) **T New Services Requested** (Patient Referred to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during a Child Health Check-Up, not including dental referrals)

837P (Electronic)

Loop 2400, **Segment SV1, Element 11** (CHCUP Indicator) – Enter "**Y**" if service is a result of a CHCUP referral. Enter "N" if indicator is equal to "NU"	**Loop 2300, Segment CRC,** (CHCUP Referral), Element 03 (Condition Code) – Enter "**AV**", "**NU**", **S2**", or "**ST**" for the referral code most applicable. If CRC02 is "**N**", this value must be "**NU**".

Appendix IX: Retrospective Review Process

As a part of the Affordable Care Act (ACA), Congress mandated that CMS reduce hospital readmissions through certain payment incentives. Section 3025 of the ACA added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

For a readmission that is determined to have been inappropriate or preventable according to the clinical review guidelines set forth below, Sunshine Health will deny payment or reimbursement.

A readmission will be considered to be inappropriate or preventable under the following circumstances:

- If the readmission was medically unnecessary;
- If the readmission resulted from a prior premature discharge from the same hospital or a related hospital;
- If the readmission resulted from a failure to have proper and adequate discharge planning;
- If the readmission resulted from a failure to have proper coordination between the inpatient and outpatient health care teams; and/or
- If the readmission was the result of circumvention of the contracted rate by the hospital or a related hospital.

The following readmissions are excluded from 30-day readmission review:

- Transfers from out-of-network to in-network facilities;
- Transfers of patients to receive care not available at the first facility;
- Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy or staged surgical procedures;
- Readmissions associated with malignancies, burns, or cystic fibrosis;
- Admissions to Skilled Nursing Facilities, Long Term Acute Care facilities, and Inpatient Rehabilitation Facilities (SNF, LTAC, and IRF);
- Readmissions where the first admission had a discharge status of “left against medical advice”;
- Obstetrical readmissions;
- Readmissions ≥ 31 days from the data of discharge from the first admission.

If a hospital is part of a hospital system operating under the same hospital agreement, and/or if the hospital shares the same tax identification number with one or more other hospitals, then a readmission during the same 30-day period to another hospital within the As a part of the Affordable Care Act (ACA), Congress mandated that CMS reduce hospital readmissions through certain payment incentives. Section 3025 of the ACA added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

Post-Payment Review

Sunshine Health will review claims data to identify instances of hospital readmissions occurring within 30-days and review such claims retrospectively.

1. If a claim is determined to be clinically related to a previous admission (and thus could possibly be determined to be an inappropriate, unnecessary, or preventable readmission), the hospital must forward (and, if applicable, arrange for a related hospital to forward) medical records for all related admissions to Sunshine Health, upon its request. All clinical information from the admissions will be reviewed by a qualified clinician to determine if any readmission was inappropriate, unnecessary, or preventable based on the above guidelines.
2. If a readmission is determined to be inappropriate, unnecessary, or preventable, written notification of such determination will be sent to the hospital or related hospital, along with a request to the hospital to refund the applicable payment(s) for the readmission, or if appropriate, the initial admission. If a hospital or related hospital fails to refund the applicable payment(s), Sunshine Health may recover the payment by offset against future payments, unless expressly prohibited by law from doing so, or as stipulated in the hospital's contract.
3. Upon request from Sunshine Health, a hospital or related hospital must forward all medical records and supporting documentation of the first and subsequent admission(s) to the health plan for review