



# **CLAIMS & BILLING SUBMISSION GUIDELINES**

Version 23.0  
2/2/2026

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## General Claims Submission Guidelines

### Paper Claims Submission

Partners Health Plan  
Claims Department  
PO Box 240356  
Apple Valley, MN 55124

### 837 Electronic Claim Submissions

PHP Providers can submit electronic institutional and professional claims via various Clearinghouses using Partners Health Plan's EDI **Payer ID# 14966**.

#### **Optum (Effective 3/11/2024):**

To submit claim via Optum call 1-866-678-8646.

### Web-Based Claims Submissions

Providers can create and upload a professional or institutional single claim as a pdf file via the provider portal ([php.healthsmart.com](http://php.healthsmart.com)). *Please note that only 1 claim should be uploaded per pdf.*

- Web-based claims are considered paper claims and will follow all existing claim submission protocols.
- Please note that only valid claim forms (CMS 1500 or UB-04) may be uploaded using this method.

## CLAIM PAYMENT OPTIONS

### New Payment Vendor Effective 4/1/2022

**Partners Health Plan**, through the administration of **HealthSmart Benefit Solutions**, has a new payment vendor, ECHO Health, Inc., effective April 1, 2022. Please note that our previous vendor, Zelis Payments, will continue to issue payments on behalf of Partners Health Plan during a run-out period through May 31, 2022.

ECHO is one of the leading payment processors in healthcare connecting over one million providers to insurance companies, health plans, and TPA's across the country. Providers will have access to numerous services including historical payments and remittance details, the electronic delivery of 1099's, and notification when new payments are available by accessing <https://providerpayments.com>. This new service will be available to all PHP Providers regardless of the payment method selected.

To sign-up to receive EFT for **HealthSmart**, please visit the following website:

<https://enrollments.echohealthinc.com/EFTERADirect/HealthSmart>

If you already have an ECHO Provider portal account or an existing ECHO Draft Number/Amount, you can use that information to enroll. However, if you do not already have an existing relationship with ECHO, you will need the unique enrollment/verification code that was sent to your organization to enroll. No Fees apply.

If you do not currently have a relationship with ECHO Health, Inc and do not have the information necessary to proactively enroll in an electronic form of payment, a paper check will be initially generated. You will then be able to utilize the draft number and amount associated with that payment to enroll in an electronic form of payment.

Once enrolled and after this transition occurs, your EFT payments from HealthSmart will appear on your bank statement from Huntington National Bank and ECHO Health Inc., as "HNB – ECHO".

If you have any difficulty with the website or have additional questions, please contact ECHO directly at 800-937-0896.

### 835 Remittance Transactions

The HealthSmart Clearinghouse will no longer accept new enrollment requests for 835 electronic remittances.

Providers can enroll to receive 835 electronic remittances with our new Payment Vendor, ECHO Health Inc.

ECHO Health has an extensive listing of trading partners including Availity.

The PHP Member Id is sent in the 835 transaction.

## Timely Filing

All claims must be submitted to Partners Health Plan within the timeframes specified by your provider contract. Claims submitted beyond the contractual timeframe will be denied for timely filing.

Non-participating providers must submit claims within 365 days/1 year from the date of service in accordance with New York State regulations.

## Calendar Year

### Professional Claims:

Multiple calendar years cannot be billed on a single claim form (i.e. Date of Service 12/26/16 and 1/4/17). Claims submitted spanning calendar years will be denied as follows:

EOB Code = BY ***The claim spans two calendar years. Please resubmit one claim per calendar year.***

## Prompt Payment

In accordance with New York State Law:

- All clean claims submitted electronically will be processed for payment within 30 days.
- All clean paper or facsimile claims will be processed for payment within 45 days.
- All claims requesting additional information or being denied will be processed within 30 days.

## Provider Billing Address

The billing address submitted on your claim does not drive updates or changes to provider records used in the processing of claims. Any payment address changes must be received by Provider Relations in writing. Please send payment address changes to [phproviders@healthsmart.com](mailto:phproviders@healthsmart.com).

## Balance Billing

Partners Health Plan's reimbursement for covered services provided to eligible participants is considered payment in full. Providers **MAY NOT** balance bill PHP's participants for the difference between the claim reimbursement and their charges.

## Place of Service Values

For the specific place of service values to be utilized on a CMS-1500 claim form in Box 24B refer to [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html)

## ICD10

All claims must be submitted with a valid ICD10 diagnosis and a diagnosis qualifier (value 0). Please be sure to include all relevant diagnosis codes and a diagnosis qualifier on your claim submission. Claims submitted with an invalid diagnosis will be denied as follows:

EOB Code = ZD ***Missing/incomplete/invalid diagnosis or condition. Please resubmit with a valid diagnosis code for further consideration of this claim.***

## Units

Only whole units should be billed on your claim submission. Partial units are not accepted for processing (i.e., 0.5).

For Home Health Care and/or Transportation Services any decimal will be rounded to the nearest whole number.

All other services will not be rounded and will be processed to the whole number as submitted on claim.

## Admit Type

All Institutional claims must be submitted with a valid Admit Type (FL14). Please refer to the following of valid Admit Types:

*1=Emergency*

*4=Newborn*

*2=Urgent*

*5=Trauma*

*3=Elective*

*9=Information not available*

## Admit Source

All Institutional claims must be submitted with a valid Admit Source (FL15). Please refer to the following of valid Admit Types:

*1=Non-Health Facility Point of Origin*

*8=Court/Law Enforcement*

*2=Clinic*

*9=Information not available*

*4=Transfer from a Hospital*

*A=Transfer from a Rural Primary Care Hospital*

*5=Transfer from a SNF or ICF*

*D=Transfer from one unit to another within same hospital requiring a separate claim to payer*

*6=Transfer from another Health Care Facility*

*E=Transfer from Ambulatory Surgery Center*

*7=Emergency Room*

## Bill Type

All Institutional claims must be submitted with a valid Bill Type (FL4). Claims submitted with an invalid Bill Type will be denied as follows:

EOB Code = LI

***Claim/Service lacks information or has submission/billing error(s)  
which is needed for adjudication***

*\*Please refer to the Partners Health Plan website [www.phpcares.org](http://www.phpcares.org) for additional Claims Processing and Encounter Reporting Guidelines referenced in Section 23 of the Provider Manual.*

## Member ID Card

The participant's ID is a 13-digit value beginning with 450000xxxxxx

### Front

 <b>Participant Name:</b> JOHN SAMPLE <b>Participant ID:</b>	<b>RxBIN:</b> 015574 <b>RxPCN:</b> ASPROD1 <b>RxGRP:</b> PNY01 <b>RxDID:</b>
<b>PHP Care Complete FIDA-IDD Plan</b> <b>Effective Date:</b> <b>PCP Name:</b>	
<b>PARTICIPANT CANNOT BE CHARGED</b> <b>Copays:</b> PCP/Specialist: \$0 ER: \$0 Rx: \$0 H9869 - 001	
	

### Back

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your Care Manager or the 24-Hour Nurse Advice line.

Participant and Provider Services.....	1-855-747-5483 (TTY: 711)
24-Hour Nurse Advice.....	1-855-769-2507 (TTY: 711)
Care Management.....	See Care Manager phone # on front of card
Pharmacy Participant and Provider Services (MedImpact).....	1-888-648-6759
Dental Services (BeneCare).....	1-800-903-3335
Hospitals: notify us within 24 hours of emergency admission.....	1-855-769-2508
Precertification/Notification.....	1-855-769-2508
Non-Emergency Transportation (Ride Health).....	1-844-982-3194

Send Claims To: Partners Health Plan P.O. Box 240356, Apple Valley, MN 55124  
Electronically Submit Claims To: Optum ID 14966  
Website: [www.phpcares.org](http://www.phpcares.org)

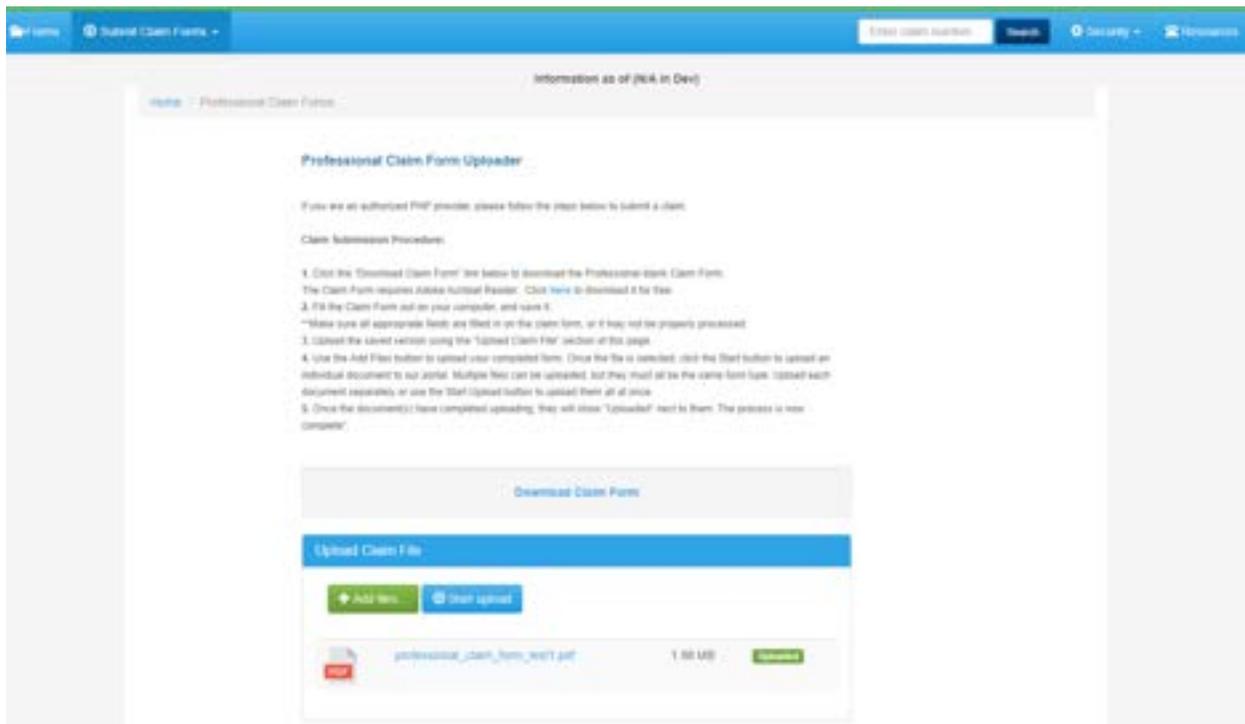
## HealthSmart PHP myTPA Provider Portal Claim Form Submission

The HealthSmart PHP myTPA Provider Portal contains a new feature that allows providers with an existing PHP myTPA Portal account to download, fill-out, and submit Professional and Institutional PDF claim forms. Any claim form submitted will be reviewed and verified for required data elements and submitted to the claim workflow process.

Web-based claims are considered paper claims and will follow all existing claim submission protocols. Claims are retrieved from the portal on the day of submission but in some cases it takes 2-3 days before they are in our core processing system because they go through a series of validation checks prior to loading to our system.

The image below depicts the process for a Professional claim form, but the process is identical for an Institutional claim form. In the image, the process has been completed as described in the instructional text and the completed PDF form has been uploaded to the portal.

To gain access to this process, login to an existing provider account or register for a new account at <https://php.healthsmart.com>, and use the top menu option labeled “Submit Claim Forms” as shown in the image below.



## General Billing Guidelines

Claims are processed on business days and are scheduled to be paid in accordance with New York State Insurance Law §3224-a. A “Clean Claim” is a claim that contains all of the data elements required by Partners Health Plan to process and adjudicate the claim including, but not limited to, all the data elements contained on a CMS-1500 form and UB-04 form. A clean claim can be processed without obtaining any additional information from the provider who rendered the service.

The following data elements are required for a claim to be considered a clean claim:

\*Please note that additional fields/data may be required in addition to the below dependent upon the type of service being billed.

**X = Required S = Situational**

Data Element	CMS-1500	Field Locator	UB-04	Field Locator
Patient Name	X	FL2	X	FL8b
Patient Date of Birth	X	FL3	X	FL10
Patient Sex	X	FL3	X	FL11
Member Name/Address	X	FL5	X	FL9
PHP Member ID Number	X	FL1a	X	FL8a, FL60
COB/Other Insured’s Information (if applicable)	X	FL9	X	FL50
Date(s) of Service	X	FL24A	X	FL45
ICD-10 Diagnosis Code(s), valid and coded to the appropriate digit and diagnosis qualifier (value 0)	X	FL21	X	FL66
ICD-10 Procedure Code(s), if applicable			X	FL74, FL74a-e
CPT-4 Procedure Code(s)	X	FL24D	S	FL44
HCPCS Code(s)	X	FL24D	S	FL44
Place of Service	X	FL24B		
Service Units	X	FL24G	X	FL46
Charges per Service	X	FL24F	X	
Total Charges	X	FL28	X	FL47
Billing Provider Name	X	FL33		
Billing Provider Address/Phone Number	X	FL33		
Service Facility Location Information	X	FL32		
National Provider Identifier (NPI)	X	FL33a	X	FL56
Tax ID Number	X	FL25	X	FL5
Hospital/Facility Name and Address			X	FL1

Pay to Address (if different than in FL1)			S	FL2
Type of Bill			X	FL4
Statement From/Through Date			X	FL6
Admission Date and Type			X	FL12, FL14
Patient Discharge Status Code			X	FL17
Condition Code(s), if applicable			X	FL18-28
Occurrence Codes and Dates, if applicable			X	FL31-34
Value Code(s) and Value Amount(s), if applicable			X	FL39-41
Revenue Code(s) & corresponding CPT/HCPCS Codes (outpatient services)			X	FL42, FL44
Principal Diagnosis, if applicable			X	FL67
Admitting Diagnosis, if applicable			X	FL68
Other ICD-10 Diagnosis Codes			X	FL67a
Attending Physician Name and NPI			X	FL76

Sample CMS 1500 Professional Claim Form



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 01/12

<input type="checkbox"/> MEDICA <span style="float: right;"><input type="checkbox"/> FECA</span>										
1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (Member Ch) <input type="checkbox"/> GROUP HEALTH PLAN (GHP) <input type="checkbox"/> FECA (LNU) (LNU) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE (MM   DD   YY) SEX (M   F)		14. INSURED'S ID NUMBER (For Program in Item 1)				
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT RELATIONSHIP TO INSURED (Self   Spouse   Child   Other)		7. INSURED'S ADDRESS (No. Street)				
CITY		STATE		8. RESERVED FOR NUCC USE		CITY		STATE		
ZIP CODE		TELEPHONE (Include Area Code)		9. RESERVED FOR NUCC USE		ZIP CODE		TELEPHONE (Include Area Code)		
8. 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				
9. OTHER INSURED'S POLICY OR GROUP NUMBER				10. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>		12. INSURED'S DATE OF BIRTH (MM   DD   YY) SEX (M   F)				
10. RESERVED FOR NUCC USE				10. AUTO ACCIDENT? (Place of) YES <input type="checkbox"/> NO <input type="checkbox"/>		13. OTHER CLAIMS (Designated by NUCC)				
11. RESERVED FOR NUCC USE				10. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		14. INSURANCE PLAN NAME OR PROGRAM NAME				
12. INSURANCE PLAN NAME OR PROGRAM NAME				10A. CLAIM CODES (Designated by NUCC)		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> (If yes, complete items 8, 9a, and 9b.)				
16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indicate the office or any medical or other information necessary to process this claim. Do not request payment of government benefits when it is to be paid or to the party who caused the assignment.)					17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Indicate the office or any medical or other information necessary to process this claim. Do not request payment of government benefits when it is to be paid or to the party who caused the assignment.)					
SIGNED: _____ DATE: _____					SIGNED: _____ DATE: _____					
18. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM   DD   YY) (Qual.)				19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (Qual.) (MM   DD   YY) FROM (MM   DD   YY) TO (MM   DD   YY)						
20. NAME OF REFERRING PROVIDER OR OTHER SOURCE (FSA   TPA   NPI)				21. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM   DD   YY) FROM (MM   DD   YY) TO (MM   DD   YY)						
22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				23. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES						
24. ICD-9-CM CODES (Qual.) (ICD-9-CM)				25. SUBMISSION CODE ORIGINAL REF. NO.						
26. ICD-9-CM CODES (Qual.) (ICD-9-CM)				27. PAVOR AUTHORIZATION NUMBER						
28. A. DATE(S) OF SERVICE (MM   DD   YY) (Qual.)		28. B. PLACE OF SERVICE (FSA   TPA   NPI)		29. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) (CPT   ICD-9-CM   MODIFIER)		30. D. DIAGNOSIS (ICD-9-CM)		31. E. CHARGES		32. F. REFERRING PROVIDER(S) (FSA   TPA   NPI)
1										NPI
2										NPI
3										NPI
4										NPI
5										NPI
6										NPI
33. FEDERAL TAX ID NUMBER (SSN   EIN)			34. PATIENT'S ACCOUNT NO.			35. ACCEPT ASSIGNMENT? (For group-term health) YES <input type="checkbox"/> NO <input type="checkbox"/>		36. TOTAL CHARGE \$		37. AMOUNT PAID \$
38. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include MD, DO, or DPM) (Verify that the statements on the reverse apply to this bill and are made a part thereof.)			39. SERVICE FACILITY LOCATION INFORMATION			40. BILLING PROVIDER INFO & NPI # ( )		41. RESERVED FOR NUCC USE		
SIGNED: _____ DATE: _____			A. _____ B. _____			C. _____ D. _____		E. _____ F. _____		

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



## CMS-1500 Claim Form Crosswalk to 837P EDI Layout

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
1a	Medicare Number	Loop 2010BA, NM1/IL, 09
2	Patient Last Name	2010BA, NM1/IL, 03
	Patient First Name	2010BA, NM1/IL, 04
3	Patient Birth Date	2010BA, DMG, 02
	Patient Sex	2010BA, DMG, 03
4	Insured Last Name	2330A, NM1/IL, 03
	Insured First Name	2330A, NM1/IL, 04
5	Patient Street Address	2010BA, N3, 01
	Patient City and State	2010BA, N4, 01 (City) 2010BA, N4, 02 (State)
	Patient ZIP Code and Phone Number	2010BA, N4, 03 (Zip Code) Phone Number not available in format
6	Patient Relationship to Insured	2000B, SBR, 02
7	Insured's Address and Phone Number	Not Used – Use only if Insured is Different than Patient
8	Patient Status	Not Used
	Patient Student Status	Not Used
	Patient Employment Status	Not Used
9	Other Insured Last Name	2330A, NM1/IL, 03
	Other Insured First Name	2330A, NM1/IL, 04
	Other Insured Middle Initial	2330A, NM1/IL, 05
9a	Other Insurance Policy or Group #	2330A, NM1/IL, 09
9b	Other Insurance Date of Birth	Not available in format
9c	Employer Name or School Name	2330B, NM1/PR, 03
9d	Insurance Plan Name or Program	2330B, NM1/PR, 09
10a,b,c	Is Patient's Condition Related To: Employment, Auto Accident, Other Accident	2300, CLM, 11
11 MSP Claims	Insured Group or Policy Number (This item must be completed for paper claims.)	Note: There is no direct match for Blocks 11 - 11D of the CMS-1500 Claim Form to the ANSI 837 v5010 format.
	Claim Filing Indicator	See note in 11
	Insurance Type Code	See note in 11
11a	Insured Date of Birth	See note in 11
11b	Employer Name or School Name	See note in 11

11c	Other Insured Group Name	See note in 11
11d	Is there another Health Benefit Plan? (Leave blank. Not required by Medicare.)	See note in 11
12	Patient Signature	2300, CLM, 10 (Patient Signature Source Code)
	Release of Information Indicator	2300, CLM, 09
14	Accident Date	2300, DTP/439, 03
	Initial Treatment Date	2300 or 2400, DTP/454, 03
15	Same/Similar Symptom Indicator	Not used
	Onset of Similar Symptoms or Illness	Not used
16	Dates patient was unable to work in current occupation	2300, DTP/360/361/or 314, 03
17	Onset of current illness or injury	2300 or 2400, DTP/431, 03
	Referring Provider Last Name	2310A or 2420F, NM1/DN, 03
	Referring Provider First Name	2310A or 2420F, NM1/DN, 04
	Ordering Provider Last Name	2420E, NM1/DK, 03
	Ordering Provider First Name	2420E, NM1/DK, 04
17a	Ordering Provider Secondary Identifier, no longer reported	Not Used
	Referring Provider Secondary Identifier, no longer reported	Not Used
17b	Ordering Provider National Provider Identifier (NPI) (17B MUST be reported when a service was ordered or referred by a physician.)	2420E, NM1/DK, 09
	Referring Provider National Provider Identifier (NPI) (17B MUST be reported when a service was ordered or referred by a physician.)	2310A or 2420F, NM1/DN, 09
19	Ordering Provider Primary Identifier (SSN or EIN)	Not Available in Format
	Referring Provider Primary Identifier (SSN or EIN)	Not Available in Format
	Referring Provider Secondary Identifier (NPI)	Not Used
	Narrative	2300, or 2400, NTE, 02
	Date Last Seen and X-ray	2300 or 2400, DTP/304, 03
	Supervising NPI	2310D or 2420D, NMI/DQ, 09
	Anesthesia Minutes	2400, SV1, 04 (03=MJ)
	Homebound Indicator	2300, CRC/75, 03
	Hospice Employed Provider Indicator	2400, CRC/70, 02
	Assumed & Relinquished Care Dates	2300, DTP/90 or 91, 03
20	Purchased Service Charges	2400, PS1, 02
21	Diagnosis 1 (Include ICD Ind. 0)	2300, HI, 01-2
	Diagnosis 2	2300, HI, 02-2
	Diagnosis 3	2300, HI, 03-2
	Diagnosis 4	2300, HI, 04-2

	Diagnosis 5	2300, HI, 05-2
	Diagnosis 6	2300, HI, 06-2
	Diagnosis 7	2300, HI, 07-2
	Diagnosis 8	2300, HI, 08-2
	Diagnosis 9	2300, HI, 09-2
	Diagnosis 10	2300, HI, 10-2
	Diagnosis 11	2300, HI, 11-2
	Diagnosis 12	2300, HI, 12-2
23	CLIA Number	2300 or 2400, REF/X4, 02
	Prior Authorization Number	2300 or 2400, REF/G1, 02
	Care Plan Oversight Services: HHA or Hospice NPI (Enter the NPI of the home health agency (HHA) or hospice when HCPCS code G0181 (HH) or G0182 (Hospice) is submitted.)	2300/REF/1J/02
24a	Dates of Service (From Dates)	2400, DTP/472, 03
	Dates of Service (To Dates)	2400, DTP/472, 03
24b	Place of Service	2300, CLM, 05 or 2400, SV1, 05
24d	Procedure Code	2400, SV1, 01-2
24e	Diagnosis Pointer	2400, SV1, 07-1
24f	Charges	2400, SV1, 02
24g	Days or Units of Service	2400, SV1, 04 (03=UN)
	Anesthesia Minutes	2400, SV1, 04 (03=MJ)
24h	Leave blank. Not required by Medicare.	Leave blank. Not required by Medicare.
24i	Legacy Qualifier Rendering Provider: (No longer reported.)	Not used
24j	Rendering Provider Legacy Number (shaded area) (No longer reported.)	Not used
	NPI of rendering provider (unshaded area)	2310B or 2420A, NM1/82, 09 (08=XX)
25	Provider SSN# or EIN#	2010AA , REF, 02 (REF01=EI or SY)
26	Patient's Account Number	2300, CLM, 01
27	Accept Assignment	2300, CLM, 07
28	Total Charges	2300, CLM, 02
29	Amount Paid	2300, AMT/F5, 02
30	Balance Due	Not Used
31	Provider Signature Indicator	2300, CLM, 06
32	Facility Lab Name	2310C, NM1/77, 03
	Facility Lab NPI	2310C, NMI/77, 09
	Place of Service Address	2310C, N3, 01

	Place of Service City	2310C, N4, 01
	Place of Service State	2310C, N4, 02
	Place of Service Zip Code	2310C, N4, 03
	Lab ID (Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.)	2400, PS1, 01
	Mammography Certification Number	2300 or 2400, REF/EW, 02
32a	Facility NPI Number	2310C, NM1/77, 09
32b	Facility Qualifier and Legacy	Not used
33	Organization Name	2010AA, NM1/85, 03
	Provider's Last Name	2010AA, NM1/85, 03
	Provider's First Name	2010AA, NM1/85, 04
	Address	2010AA, N3, 01
	City	2010AA, N4, 01
	State	2010AA, N4, 02
	Zip Code	2010AA, N4, 03
33a	Billing Provider NPI	2010AA/NM1/85/09 (08 = XX)

## UB-04 Claim Form Crosswalk to 837I EDI Layout

Form Locator #	Description	ASC 837I v5010A2 Loop, Segment
1	Billing Provider, Name, Address and Telephone Number	Loop 2010AA, NM1/85/03, N3 segment, N4 segment
2	Pay-to-Name and Address (required when different from form locator 01)	Loop 2010AB, NM1/77/03, N3 segment, N4 segment
03a	Patient Control Number*	Loop 2300, CLM01
03b	Medical Record Number	Loop 2300, REF/EA/02
4	Type of Bill	Loop 2300, CLM05-1, CLM05-3
5	Federal Tax ID Pay-to-provider = to the Billing Provider Pay-to-provider not = to the Billing PROV	Loop 2010AA, NM109, REF/EI/02 Loop 2010AB, NM109, REF/EI/02
6	Statement Covers Period (MMDDYY)	Loop 2300, DTP/434/03
7	Reserved for future use	
08a	Patient Name When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, NM1/IL/03, 04, 05, 07 Loop 2010CA, NM1/QC/03, 04, 05, 07
08b	Patient Identifier When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, NM1/IL/09 Loop 2010CA, NM1/QC/09
09a-e	Patient Address When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, N301, N401,02,03,04 Loop 2010CA, N301, N401,02,03,04
10	Patient Birth Date When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, DMG02 Loop 2010CA, DMG02
11	Patient's sex When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, DMG02 Loop 2010CA, DMG02
12	Admission/Start of Care Date	Loop 2300, DTP/435/03
13	Admission Hour	Loop 2300, DTP/435/03
14	Priority (Type) of Visit	Loop 2300, CL101
15	Source of Admission	Loop 2300, CL102
16	Discharge Hour	Loop 2300, DTP/096/03
17	Institutional Claim Code	Loop 2300, CL103

18-28	Condition Codes	Loop 2300, HI01-2 (HI01-1=BG) Loop 2300, HI02-2 (HI02-1=BG) Loop 2300, HI03-2 (HI03-1=BG) Loop 2300, HI04-2 (HI04-1=BG) Loop 2300, HI05-2 (HI05-1=BG) Loop 2300, HI06-2 (HI06-1=BG) Loop 2300, HI07-2 (HI07-1=BG)
29	Auto State	Loop 2300, CLM11-4
30	Reserved for future use	
31-34	Occurrence Code/Date	Loop 2300, HI01-2 (HI01-1= BH) HI01-4 Loop 2300, HI02-2 (HI02-1= BH) HI02-4 Loop 2300, HI03-2 (HI03-1= BH) HI03-4 Loop 2300, HI04-2 (HI04-1= BH) HI04-4 Loop 2300, HI05-2 (HI05-1= BH) HI05-4 Loop 2300, HI06-2 (HI06-2= BH) HI06-4 Loop 2300, HI07-2 (HI07-1= BH) HI07-4 Loop 2300, HI08-2 (HI08-1= BH) HI08-4
35-36	Occurrence Span Code/Date	Loop 2300, HI01-2 (HI01-1=BI) HI01-4 Loop 2300, HI02-2 (HI02-1= BI) HI02-4 Loop 2300, HI03-2 (HI03-1= BI) HI03-4 Loop 2300, HI04-2 (HI04-1= BI) HI04-4
37	Reserved for future use	
38	Responsible Party	Not required by Medicare
39-41	Value Code/Amount	Loop 2300, HI01-2 (HI01-1= BE) HI01-5 Loop 2300, HI02-2 (HI02-1= BE) HI02-5 Loop 2300, HI03-2 (HI03-1= BE) HI03-5 Loop 2300, HI04-2 (HI04-1= BE) HI04-5 Loop 2300, HI05-2 (HI05-1= BE) HI05-5 Loop 2300, HI06-2 (HI06-1= BE) HI06-5 Loop 2300, HI07-2 (HI07-1= BE) HI07-5 Loop 2300, HI08-2 (HI08-1= BE) HI08-5 Loop 2300, HI09-2 (HI09-1= BE) HI09-5 Loop 2300, HI10-2 (HI10-1= BE) HI10-5 Loop 2300, HI11-2 (HI11-1= BE) HI11-5 Loop 2300, HI12-2 (HI12-1= BE) HI12-5
42	Revenue Code	Loop 2400, SV201
43	Revenue Description	Not Required by Medicare
44	HCPCS/Rate/HIPPS Code	Loop 2400, SV202-2 (SV202-1=HC/HP)
45	Service Date	Loop 2400, DTP/472/03
46	Service/Units	Loop 2400, SV205
47	Total Charges	Loop 2400, SV203
48	Nov-Covered Charges	Loop 2400, SV207
49	Save for Future Use	Not required by Medicare
50a-c	Name Last or Organization Name Other Payer Last or Organization Name	Not Required for 5010 Loop 2330B, NM1/PR/03

51	Identification Code Other Payer Primary Identifier	Not Required for 5010 Loop 2330B, NM1/PR/09
52	Release of Information	Loop 2300, CLM07
53	Assignment of Benefits Certification	Loop 2300, CLM08
54	Prior Payment Amounts	Loop 2320, AMT/D/02
55a-c	Estimated Amount Due	Loop 2300, AMT/EAF/02
56	National Provider Identifier (NPI)	Loop 2010AA, NM1/85/09
57a-c	Billing Provider Tax ID	Loop 2010AA, REF/EI/02
58a-c	Insured's Name Other Insured's Name	Loop 2010BA, NM1/IL/03, 04, 05 Loop 2330A, NM1/IL/03, 04, 05
59a-c	Patient Relationship	Loop 2000B, SBR02
60a-c	Subscriber Identification Code	Loop 2010BA, NM1/IL/09, REF/SY/02
61	Group Name	Loop 2000B,SBR04
62	Insurance Group No.	Loop 2000B,SBR03
63	Treatment Authorization Codes	Loop 2300,REF/G1/02
64	Document Control Number	Loop 2300,REF/F8/02
65	Employer Name	Loop 2320
66	Dx & Procedure Code Qualifier	Include Qualifier Value "0"
67a-q	Diagnosis	Loop 2300, HI01-2 (HI01-1=BK)
68	Reserved for future use	
69	Admitting Dx	Loop 2300, HI02-2 (HI02-1=BJ)
70a-c	Patient Reason for Visit	Loop 2300, HI02-2 (HI02-1=PR)
71	Diagnosis Related Group (DRG) Code	Loop 2300, HI01-2 (HI01-1=DR)
72a-c	External Cause of Injury Code	Loop 2300, HI03-2 (HI03-1= BN)
73	Reserved for future use	
74	Principal Procedure Code Principal Procedure Date	Loop 2300, HI01-2 (HI01-1= BR) Loop 2300, HI01-4 (HI01-1=BR)
74a-e	Other Procedure Information	Loop 2300, HI01-2 (HI01-1=BQ) Loop 2300, HI01-4 (HI01-1=BQ) Loop 2300, HI02-2 (HI02-1=BQ) Loop 2300, HI02-4 (HI02-1=BQ) Loop 2300, HI03-2 (HI03-1=BQ) Loop 2300, HI03-4 (HI03-1=BQ) Loop 2300, HI04-2 (HI04-1=BQ) Loop 2300, HI04-4 (HI04-1=BQ) Loop 2300, HI05-2 (HI05-1=BQ) Loop 2300, HI05-4 (HI05-1=BQ)
75	Reserved for future use	

76	Attending Provider Name	Loop 2310A, NM1/71/09
	Attending Provider Secondary ID	Loop 2310A, REF02 (REF01= 0B/1G/G2/or LU
	Attending Provider Last Name	Loop 2310A, NM1/71/03
	Attending Provider First Name	Loop 2310A, NM1/71/04
77	Operating Physician Name	Loop 2310B, NM1/72/09
	Operating Physician Secondary ID	Loop 2310B, REF02 (REF01= 0B/1G/G2/or LU
	Operating Physician Last Name	Loop 2310B, NM1/72/03
	Operating Physician First Name	Loop 2310B, NM1/72/04
78	Other Operating Physician Name	Loop 2310C, NM1/ZZ/09
	Other Operating Physician Secondary ID	Loop 2310C, REF02 (REF01= 0B/1G/G2/or LU
	Other Operating Physician Last Name	Loop 2310C, NM1/ZZ/03
	Other Operating Physician First Name	Loop 2310C, NM1/ZZ/04
79	Not Crosswalked	
80	Claim Note Claim Note Text	Loop 2300, NTE/ADD/01 Loop 2300, NTE02 (NTE01=ADD)

\*Note: Only the 1<sup>st</sup> 15 characters of the Patient Control # will be utilized within the claim processing system and reflected on the Explanation of Benefits in the Patient # field.

**Patient Control Number**

The Patient Control Number in FL3A is an internal identifier utilized by many providers. If you submit an internal reference number in this field it will be referenced on the Explanation of Benefits you receive with your claim payment.

**Units**

Claims must be billed in whole units.

**Explanation of Benefits Example**

Partners Health Plan  
P.O. Box 16309  
Lubbock, TX 79490



Your name, [redacted] and Tax ID have been verified by the IRS.

For Customer Service, please call 1-855-747-5483 from 8am-6pm EST or utilize our claims/eligibility portal at

Tax ID: [redacted] EPC Draft #: [redacted] Payment Week: 48 Payment Date: 11/28/2022 Page 1 of 3

Dates of Service	Code or Description	Total Charge	Discount	Other Plan Payment	Other Adjustment	Allowed Amount	Patient Responsibility			Payment Amount	Explanation Codes
							Co-ins	Co-pay	Deductible Not Covered		
08/08/22-08/08/22	1546	120.75	0.00	0.00	(0.16)	120.75	0.00	0.00	0.00	0.00	AGPH SCPH
<b>Total:</b>		120.75	0.00	0.00	(0.16)	120.75	0.00	0.00	0.00	120.91	

Provider: [redacted] Patient Acct #: [redacted] Group/Check Number: 4500-000000000132762  
 Network: [redacted] Member Number: [redacted] Group Name: PARTNERS HEALTH PLAN  
 Patient Name: [redacted] Claim Number: [redacted] Customer Service #: 1-855-747-5483

**\*The Other Adjustment amount reflects the difference between the Total Charge and the Payment Amount.**

**\*\*If you are a PHP in-network provider, the Payment Among will be based on your contract. If you are an out-of-network provider, your payment amount will be based on the Medicare of Medicaid fee-for service equivalent based on the type of service provided unless negotiated otherwise.**

## Clinical and Claim Appeal Guidelines

### To request a **Clinical Appeal**:

- Non-contracted Providers: 60 days from 12/31/2025 - Anything submitted after 3/1/26 will be dismissed.
- Contracted Providers: 60 days or per contract
- Address:  
PHP Care Complete FIDA-IDD Plan  
Appeals Department  
4700 MacCorkle Ave SE, Ste 104  
Charleston, WV 25304-1922

### To request a **Payment Appeal**:

- Non-contracted Providers: 60 days from date on remittance
- Contracted Providers: 60 days from date on remittance or per contract
- Address:  
PHP Care Complete FIDA-IDD Plan  
Appeals Department  
P.O. Box 240356  
Apple Valley, MN 55124-0356

For additional questions or assistance contact Provider Services at 1-855-747-5483 with claim and participant ID number.

Full appeal instructions are available for review in the Provider Manual or visit our website at [www.phpcares.org](http://www.phpcares.org).

## Office for People with Developmental Disabilities (OPWDD) Services

### Claim Form

All claims for OPWDD Services should be submitted on the UB-04 claim form or in the 837I EDI format.

\*If claims for OPWDD Services are submitted on a CMS-1500 professional form they will be denied with the EOB message **CLA – INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.** (RARC = N34)

### Rate Codes

Refer to the following link for the listing of OPWDD Rate Codes: [OPWDD Rate Codes](#)

\*SUBJECT TO CHANGE IF REVISED BY NYSDOH

The Rate Code is to be entered in the Value Amount field with a Value Code of 24 (FL39-FL41).

### Revenue Code

Revenue Code 0240 (All Inclusive Ancillary) should be utilized. It should be entered in FL42 on the UB-04.

### Diagnosis Code

ICD-10 Diagnosis Code R69 (illness, unspecified) may be utilized as a default in the absence of a more specific diagnosis.

### Bill Type

Bill Type 891 may be utilized for the submission of OPWDD Services with exception of claims submitted with Rate Codes 1537, 1546, and 1549. The 3<sup>rd</sup> digit of the bill type is the claim frequency code and should be submitted as applicable to the claims submission (1 = Original, 3 = Interim, 7 = Correction, 8 = Void).

### Admit Date

The Admit Date in FL12 should be the start date of the episode of care being billed on the claim form. It should be equal to the first date of service on the claim being billed.

### Statement From and Through Dates

All dates must be entered in the format MMDDYYYY.

Statement From and Through Dates are to be entered in FL6 using the following guidelines:

- 1) **\*Monthly:** If billing for monthly rates (i.e., rate code 4709), only one date of service can be billed per claim form. Enter the last day of the month being billed (i.e., billing for month of June then enter 06302016) as the date of service on the line level. The Statement From and Statement Through date should represent the range of dates in the month (i.e., billing for month of June then enter as 06012016 – 06302016).
- 2) **\*\*Daily:** If the rate code allows for only one unit of service per day (i.e., rate code 4453), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016....06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).
- 3) **\*\*\*Hourly:** If the rate code allows multiple units of service (hours, hour fractions, etc.) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

#### Locator Codes

Claims for members that have been approved as highly complex/specialized will require manual pricing to be paid to the enhanced rates.

The claim should be submitted with the appropriate locator code and value code 61 in FL39-41.

#### Units

All claims for DD services will be entered as the whole number only.

- Example: If billed as 4.5 units the claim will be processed using 4 units.

Please complete the following form and email to [rateupdates@phpcares.org](mailto:rateupdates@phpcares.org)

FACILITY NAME:
TAX ID:
AS OF:

	Current Effective Rate 07/01/2025-12/31/2025	Medicaid Rate Code	Locator code
ICF		3822	003
Group DH Full Day Highly Complex FEE ICF		4104	029
Day Hab Services (ICF) Full Day		4104	027
Group DH Half Day Highly Complex FEE ICF		4105	029
Day Hab Services (ICF) Half Day		4105	027
In House Day Services Full ICF		4108	065
SUPV IRA		4437,4438,4439	005
SUPV IRA Specialized (Template) FEE		4437,4438,4439	006
SUPV IRA Highly Complex FEE		4437,4438,4439	007
SUPV IRA SNF Transfer (or Auspice Change) FEE		4437,4438,4439	008
Group DH Full Day Specialized (Template) FEE		4453	019
Group DH Full Day Highly Complex FEE IRA		4453	021
Group DH Half Day		4454	003
Group DH Half Day Specialized (Template) FEE		4454	019
Group DH Half Day Highly Complex FEE IRA		4454	021
Supp DH Full Day (Saturday)		4455	005
Supp DH Half Day (Saturday)		4456	005
Pre Voc Full		4464	004
Pre Voc Half		4465	004
SUPT IRA (Monthly)		4709	003
SUPT IRA ( 1st half Monthly)		4710	003
SUPT IRA (2nd half Monthly)		4711	003
Community Habilitation FEE (Qtr Hr) individual		4722	009
Community Habilitation FEE (Qtr Hr) group 2		4723	009
Community Habilitation FEE (Qtr Hr) group 3		4724	009
SEMP Phase 1- INDIVIDUAL (Qtr Hr)		4759	037
SEMP Phase 1- GROUP (Qtr Hr)		4760	037
SEMP via FI Phase 2 - GROUP (Qtr Hr)		4772	
Respite (Qtr Hr)		4774	072
Prevoc Community GROUP of 3+ (Qtr Hr)		4783	67
SEMP Intensive- INDIVIDUAL (Qtr Hr)		4790	058
SEMP Intensive- GROUP (Qtr Hr)		4791	058
SEMP Phase 2- INDIVIDUAL (Qtr Hr)		4792	058
Community Habilitation FEE (Qtr Hr) group 2		4793	063
SEMP Phase 2- GROUP (Qtr Hr)		4793	058
Community Habilitation / IRA FEE (Qtr Hr)		4796	063

**\*\*Non-Participating Providers are NOT to utilize this form.**

Rate changes/updates are loaded to our system within 30 days of being publicly posted.

PHP does not retroactively adjust rates for Non-Participating Providers.

OPWDD Service Claim Layout Example

1 Facility Address 1 City, State Zip		2 Pay to Facility Pay to Address City, State Zip		3 Patient Control # (Internal ref # as applicable) Medical Record #		4 TYPE OF BILL XXXX	
5 PATIENT NAME Member ID #		6 PATIENT ADDRESS Member Street Address		7 TIN #		8 STATEMENT COVERED PERIOD From Date Through Date	
9 Member Last Name, First Name MI		10 Member City		11 State		12 Zip	
13 BIRTH DATE Member DOB		14 SEX M/F		15 ADMIT DATE		16 TYPE	
17 OCCURRENCE DATE		18 OCCURRENCE DATE		19 OCCURRENCE DATE		20 OCCURRENCE DATE	
21		22		23		24	
25		26		27		28	
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37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
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797		798		799		800	
801		802		803		804	
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809		810		811		812	
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849		850		851		852	
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873		874		875		876	
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881		882		883		884	
885		886		887		888	
889		890		891		892	
893							

## Day Habilitation Services

### **Rate Codes:**

The following rate codes should be utilized when submitting a claim for Day Habilitation Services:

<b><i>Rate Code</i></b>	<b><i>Description</i></b>
4453	Group DH Full Day
4454	Group DH Half Day
4455	Supplemental Group DH Full Day
4456	Supplemental Group DH Half Day

\*Only one Rate code may be submitted per claim

### **Claim Form:**

Day Habilitation Services should be billed on a UB-04 claim form or in the 837I format.

### **Dates of Services:**

Report the span of dates of service being reported in the Statement From/Through Dates.

Each individual date of service is to be submitted on an individual claim line.

### **Locator Codes:**

Claims for members that have been approved as highly complex/specialized will require manual pricing to be paid to the enhanced rates.

The claim should be submitted with the appropriate locator code and value code 61 in FL39-41.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Day Habilitation Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 PATIENT CONTROL # MEDICAL RECORD #		4 891	
5 PATIENT NAME 4500000999999		6 PATIENT ADDRESS 123 MAIN STREET		7 CITY, STATE ZIP NY 11999		8	
9 BIRTHDATE 010147		10 SEX 3		11 ADMISSION DATE 012317		12 DISCHARGE DATE 3 9	
13 OCCURRENCE CODE		14 OCCURRENCE DATE		15 OCCURRENCE DATE		16 OCCURRENCE DATE	
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893		894					

## Supervised IRA

### **Rate Codes:**

The following rate codes should be utilized when submitting a claim for Supervised IRA Services:

<b><i>Rate Code</i></b>	<b><i>Description</i></b>
4437	IRA Supvd; Per Diem
4438	IRA Supvd; Med Leave; Per Diem
4439	IRA Supvd; Non-Med Leave; Per Diem

\*Only one Rate code may be submitted per claim

### **Claim Form:**

Supervised IRA Services should be billed on a UB-04 claim form or in the 837I format.

### **Dates of Services:**

Report the span of dates of service being reported in the Statement From/Through Dates.

Each individual date of service is to be submitted on an individual claim line.

### **Bed Hold:**

Medical Leave Prior to 7/1/19:

If a participant leaves the facility for a medical leave and the facility holds the bed, submit rate code 4438. There is a 14-day limitation which is referred to as retainer days. The 14-day limitation is applied per person per rate year.

The claim for medical leave should be submitted using charges for the days for which you are expecting reimbursement. If submitting 4438 for reporting purposes only, outside of the 14-day limitation, bill zero charges.

Medical Leave 7/1/19 and forward:

Retainer day payments are based on the certified capacity operated by each individual agency. Though there is still a limit on payment for retainer days, providers will no longer be limited to 14 allowable retainer days per individual per rate year but the limit will be based upon the certified capacity. The update to the retainer day methodology does not change any claim submission process. All retainer days should continue to be submitted for processing.

Non-Medical Leave:

If a participant leaves the facility for a therapeutic leave (non-medical) and the facility holds the bed, submit rate code 4439. There is no limitation on therapeutic leave but It must be justified in the life plan (requires Partners Health Plan approval).

**Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Supervised IRA Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 THE PATIENT CONTROL # MEDICAL RECORD #		4 THE BILL OF BILL	
5 PATIENT NAME 4500000999999		6 PATIENT ADDRESS 123 MAIN STREET		7 FED TAX NO 123456789		8 STATEMENT COVERING PERIOD FROM 020417 THROUGH 020417	
9 SMITH, MARY		10 ANYWHERE		11 NY 11999			
12 00147 F 020417 3 9 30		13 ADMISSION 13 MO 14 TIME 15 SEC 16 CHRG 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99		14 CONDITION CODES			
15 OCCURRENCE CODE		16 OCCURRENCE DATE		17 OCCURRENCE DATE		18 OCCURRENCE DATE	
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## Self-Directed Services

### **Direct Services:**

Direct Services are agency supported self-direction in which the participant chooses the provider (agency). The provider submits their claims directly to Partners Health Plan's TPA for processing.

### **Indirect Services:**

Indirect Services are known as self-direction via the Fiscal Intermediary (FI). The FI chooses the provider (agency) rather than the member and the FI arranges for care. The provider then bills the FI for the services and is paid by the FI. The FI then bills Partners Health Plan for both their monthly FI fee and for the reimbursement of the amount that they paid to the self-directed services provider (agency).

### **Rate Codes:**

The following rate codes should be utilized when submitting a claim for Self-Directed Services:

<b><i>Rate Code</i></b>	<b><i>Description</i></b>	<b><i>Locator Code</i></b>
4787	Fiscal Intermediary; Vol; Level 1	56
4789	Fiscal Intermediary; Vol; Level 3 (PRA Amount under 60K)	56
4789	Fiscal Intermediary; Vol; Level 3 (PRA Amount over 60K)	57
4778	Support Broker; Via FI; Vol; ¼ Hr	

\*Rate code 4788 (Fiscal Intermediary; Vol; Level 2) is not covered by Partners Health Plan

### **Claim Form:**

Self-Directed Services should be submitted on a UB-04 claim form.

### **Rate Codes:**

The Rate Code is to be entered in the Value Amount field with a Value Code of 24 (FL39-FL41).

Only one rate code may be submitted per claim.

### **Statement From and Through Dates:**

All dates must be entered in the format MMDDYYYY.

Statement From and Statement Through date should represent the range of dates in the month (i.e., billing for month of June then enter as 06012016 – 06302016).

**Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

**Claim Submission:**

Self-Directed claims may be submitted electronically or to the designated PO Box. Please refer to the section on page 2 of this document ***General Claims Submission Guidelines*** for details.

**Self-Direction Inquiries:**

All Self-Direction inquiries related to start up budgets, broker agreements, budget amendments, and budget approvals should be directed to the designated Self-Direction inbox at [selfdirection@phpcares.org](mailto:selfdirection@phpcares.org).

Self-Directed Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 PATIENT CONTROL # MEDICAL RECORD #		4 ZIP OF BILL 391	
5 PATIENT NAME 4500000999999		6 PATIENT ADDRESS 123 MAIN STREET		7 CITY STATE ZIP NY 11999			
8 BIRTHDATE 010147 SEX F DATE 020117		9 CONDITION CODES 3 9		10 STATE 30			
11 OCCURRENCE DATE		12 OCCURRENCE DATE		13 OCCURRENCE DATE		14 OCCURRENCE DATE	
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819		820		821		822	
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839		840		841		842	
843		844		845		846	
847		848		849		850	
851		852		853		854	
855		856		857		858	
859		860		861		862	
863		864		865		866	
867		868		869		870	
871		872		873		874	
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883		884		885		886	
887		888		889		890	
891		892		893			

## Pathways to Employment Services

### **Rate Code/Units:**

Rate Code	Definition	Units
4444	Path to Employment; Vol; Indiv; ¼ hr	1 unit = 15 minutes
4445	Path to Employment; Vol; Group; ¼ hr	1 unit = 15 minutes

### **Dates of Service:**

**Hourly:** If the rate code allows multiple units of service (quarter-hour increments) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

### **Claim Form:**

Services should be billed on a UB-04 claim form or in the 837I format.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.



## ICF Services

### **Rate Code/Units:**

Rate Code	Definition	Units
3822	ICF	1 unit = single date of service

### **Dates of Service:**

Daily: If the rate code allows for only one unit of service per day (i.e., rate code 3822), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016...06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

### **Claim Form:**

Services should be billed on a UB-04 claim form or in the 837I format.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

ICF Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 PATIENT CONTROL # MEDICAL RECORD #		4	
5 PATIENT NAME a 4500000999999		6 PATIENT ADDRESS k 123 MAIN STREET		7		8	
9 SMITH, MARY		10 ANYWHERE		11 NY		12 11999	
13 BIRTH DATE 010147		14 SEX F		15 DATE 010317		16 AGE 39	
17 CHRG 30		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
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49		50		51		52	
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## ICF Day Services

### **Rate Code/Units:**

Rate Code	Definition	Units
4104	ICF; Vol; Day Service; Full Unit	1 unit = single date of service
4105	ICF; Vol: Day Service: Half Unit	1 unit = single date of service

### **Dates of Service:**

**Daily:** If the rate code allows for only one unit of service per day (i.e., rate code 4453), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016....06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

### **Claim Form:**

Services should be billed on a UB-04 claim form or in the 837I format.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

ICF Day Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 INTR. CONT. # MEDICAL RECORD #		4 PLAN OF BLD 891	
5 PATIENT NAME * 4500000999999		6 RESIDENT ADDRESS * 123 MAIN STREET		7 FED. TAX NO. 123456789		8 ESTIMATED COVERAGE PERIOD FROM 010317 THROUGH 010317	
9 SMITH, MARY		10 ANYWHERE		11 NY		12 11999	
13 BIRTHDATE 010147		14 SEX F		15 ADMISSION DATE 010317		16 TYPE 3	
17 OCCURRENCE DATE		18 OCCURRENCE DATE		19 OCCURRENCE DATE		20 OCCURRENCE DATE	
21 VALUE CODES AMOUNT		22 VALUE CODES AMOUNT		23 VALUE CODES AMOUNT		24	
25 24 4004.00		26 81 27.00		27		28	
29 240		30 DESCRIPTION		31 ICD-9-CM CODE 010317		32 UNITS 1.0	
33 TOTAL CHARGES 250.00		34 NON-COVERED CHARGES		35		36	
PAGE OF		CREATION DATE		TOTALS		250.00	
37 PRINTER NAME PARTNER'S HEALTH PLAN		38 HEALTH PLAN ID		39 PRIOR PAYMENTS Y		40 EST. ACCOUNT DUE Y	
41 REFERENCE NAME SMITH, MARY		42 REFERENCE UNIQUE ID 18 4500000999999		43 GROUP NAME		44 INSURANCE GROUP NO.	
45 TREATMENT AUTHORIZATION CODES		46 DOCUMENT CONTROL NUMBER		47 EMPLOYER NAME		48	
49 1.59		50		51		52	
53 ADMIT CODE		54 DISMIT REASON CODE		55 OTHER PROCEDURE CODE		56 OTHER PROCEDURE DATE	
57 OTHER PROCEDURE CODE		58 OTHER PROCEDURE DATE		59 OTHER PROCEDURE CODE		60 OTHER PROCEDURE DATE	
61 REMAINS		62		63		64	
65 OTHER		66		67		68	
69 OTHER		70		71		72	
73 OTHER		74		75		76	
77 OTHER		78		79		80	
81 OTHER		82		83		84	
85 OTHER		86		87		88	
89 OTHER		90		91		92	
93 OTHER		94		95		96	
97 OTHER		98		99		100	

## Supportive IRA Services

### **Rate Code/Units:**

Rate Code	Definition	Units	Statement From/Through Dates
4709	Res Hab; Vol; IRA/Cr-Suprt Monthly	1 unit = month	1 <sup>st</sup> of the month through last day of month (i.e., 06012016-06302016)
4710	Res Hab; Vol; IRA/CR-Suprt Semi-Monthly 1 <sup>st</sup> Half	1 unit = half of month	1 <sup>st</sup> through the 15 <sup>th</sup> of the month (i.e., 06012016-06152016)
4711	Res Hab; Vol; IRA/CR-Suprt Semi-Monthly 2 <sup>nd</sup> Half	1 unit = half of month	16 <sup>th</sup> through the last day of the month (i.e., 06162016-06302016)

### **Dates of Service:**

**Monthly:** If billing for monthly rates (i.e., rate code 4709), only one date of service can be billed per claim form. Enter the last day of the month being billed (i.e., billing for month of June then enter 06302016) as the date of service on the line level. The Statement From and Statement Through date should represent the range of dates in the month (i.e., billing for month of June then enter as 06012016 – 06302016).

When billing with a Semi-Monthly rate code (i.e., 4710), the date of service on the line level should be last date of the period being billed (i.e., billing for the 1<sup>st</sup> half of June then enter 061516). The Statement From and Statement Through date should represent the range of dates for the billing period for the rate code (i.e., billing for June 1-15 then enter as 06012016-06152016)

### **Claim Form:**

Services should be billed on a UB-04 claim form or in the 837I format.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Supportive IRA Service Claim Layout Example (Full Month):

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 PATIENT CONTROL # MEDICAL RECORD #		4 STATE OF BILL 891	
5 PATIENT NAME 4500000999999		6 PATIENT ADDRESS 123 MAIN STREET		7 CITY NY 8 ZIP 11999			
9 IDENTIFIER 010147 F		10 DATE 010117		11 MONTHS 3 12 DAYS 9		13 STATE 30	
14 OCCURRENCE DATE		15 OCCURRENCE DATE		16 OCCURRENCE DATE		17 OCCURRENCE DATE	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
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70		71		72		73	
74		75		76		77	
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## Respite Services

### **Rate Code/Units:**

Rate Code	Definition	Units
7421	In-Home Respite	1 unit = 15 minutes
7422	Site-Based Respite	1 unit = 15 minutes
7423	Recreational Respite	1 unit = 15 minutes
7424	Camp	1 unit = 15 minutes
7425	Intensive	1 unit = 15 minutes
7426	In-Home Agency Supported Self Direction	1 unit = 15 minutes
7427	Intensive In-Home Agency Self Direction	1 unit = 15 minutes
7428	In-Home Per Diem	1 unit = single date of service
7429	Site-Based Per Diem	1 unit = single date of service

### **Dates of Service:**

**Hourly:** If the rate code allows multiple units of service (quarter-hour increments) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

**Daily:** If the rate code allows for only one unit of service per day (i.e., rate code 4453), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016...06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

### **Claim Form:**

Services should be billed on a UB-04 claim form or in the 837I format.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.



## Prevocational Services

Rate Code	Definition	Units
4464	Prevoc; Voluntary; Full Unit/OPWDD	1 unit = single date of service
4465	Prevoc; Voluntary; Half Unit/OPWDD	1 unit = single date of service

### **Dates of Service:**

Daily: If the rate code allows for only one unit of service per day (i.e., rate code 4453), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016....06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

### **Claim Form:**

Services should be billed on a UB-04 claim form or in the 837I format.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Prevocational Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 PATIENT CONTROL # MEDICAL RECORD #		4 ITEM OF BILL 391	
5 PATIENT NAME 4500000999999		6 PATIENT ADDRESS 123 MAD STREET		7 CITY NY 8 STATE NY 9 ZIP 11999			
10 ICD-9-CM CODE 010147		11 SEX F		12 DATE 012317		13 AGE 3 14 SEX 9	
15 OCCURRENCE DATE		16 OCCURRENCE DATE		17 OCCURRENCE DATE		18 OCCURRENCE DATE	
19 CODE		20 CODE		21 CODE		22 CODE	
23 VALUE CODE AMOUNT 24 4484.00		25 VALUE CODE AMOUNT 26 61 4.00		27 VALUE CODE AMOUNT		28 VALUE CODE AMOUNT	
29 DESCRIPTION		30 LEVY DATE 012317		31 QUANTITY 1.0		32 RATE 250.00	
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## Community Habilitation Services

### **Rate Code/Units:**

Rate Code	Definition	Units
4722	Comm/Res Hab; Vol; Indiv; ¼ hr	1 unit = 15 minutes
4723	Comm/Res Hab; Vol; Group – 2 individuals; ¼ hr	1 unit = 15 minutes
4724	Comm/Res Hab; Vol; Group – 3 individuals; ¼ hr	1 unit = 15 minutes
4725	Comm/Res Hab; Vol; Group – 4 individuals; ¼ hr	1 unit = 15 minutes
4755	Com Hab; Agy Sup; Ind; ¼ Hr	1 unit = 15 minutes
4756	Com Hab; Agy Sup; Grp; ¼ Hr	1 unit = 15 minutes
4757	Com Hab; Cert Fac Resid; Agy Sup; Vol: Ind; ¼ Hr	1 unit = 15 minutes
4758	Com Hab; Cert Fac Resid; Agy Sup; Vol: Grp; ¼ Hr	1 unit = 15 minutes

### **Dates of Service:**

**Hourly:** If the rate code allows multiple units of service (quarter-hour increments) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

### **Claim Form:**

Services should be billed on a UB-04 claim form or in the 837I format.

### **Units:**

Claims must be billed in whole units. If partial units are submitted, they will be rounded down to the nearest whole number for reimbursement purposes. Units will not be rounded up.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Community Habilitation Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 PATIENT CONTROL # MEDICAL RECORD #		4 STATE OF RES. 891	
5 PATIENT NAME 4500000999999		6 PATIENT ADDRESS 123 MAIN STREET		7 FED TAX NO 123456789		8 STATEMENT COVERED PERIOD FROM 012317 THROUGH 012517	
9 SMITH, MARY		10 ANYWHERE		11 NY		12 11999	
13 BIRTHDATE 000147		14 SEX F		15 ADMISSION DATE 012317		16 DISCHARGE DATE 3 9	
17 OCCURRENCE CODE		18 OCCURRENCE DATE		19 OCCURRENCE DATE		20 OCCURRENCE DATE	
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## Supported Employment (SEMP)

### **Rate Code/Units:**

Rate Code	Definition	Units
4759	SEMP; Agy Sup; Phase 1; Vol; Ind; ¼ Hr	1 unit = 15 minutes
4760	SEMP; Agy Sup; Phase 1; Grp; Ind; ¼ Hr	1 unit = 15 minutes
4761	SEMP; Agy Sup; Phase 2; Vol; Ind; ¼ Hr	1 unit = 15 minutes
4762	SEMP; Agy Sup; Phase 2; Grp; Ind; ¼ Hr	1 unit = 15 minutes
4769	SEMP; Via Fl; Phase 1; Vol; Ind; ¼ Hr	1 unit = 15 minutes
4770	SEMP; Via Fl; Phase 1; Grp; Ind; ¼ Hr	1 unit = 15 minutes
4771	SEMP; Via Fl; Phase 2; Vol; Ind; ¼ Hr	1 unit = 15 minutes
4772	SEMP; Via Fl; Phase 2; Grp; Ind; ¼ Hr	1 unit = 15 minutes
4790	SEMP; Intensive; Vol; Ind; ¼ Hr	1 unit = 15 minutes
4791	SEMP; Intensive; Vol; Grp; ¼ Hr	1 unit = 15 minutes
4792	SEMP; Extended; Vol; Ind; ¼ Hr	1 unit = 15 minutes
4793	SEMP; Extended; Vol; Grp; ¼ Hr	1 unit = 15 minutes

### **Dates of Service:**

**Hourly:** If the rate code allows multiple units of service (quarter-hour increments) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

### **Claim Form:**

Services should be billed on a UB-04 claim form or in the 837I format.

### **Units:**

Claims must be billed in whole units. If partial units are submitted, they will be rounded down to the nearest whole number for reimbursement purposes. Units will not be rounded up.

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Supported Employment Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP		2 FACILITY PAY TO ADDRESS CITY, STATE ZIP		3 PATIENT CONTROL #		4 PLAN #	
4 IDENT NAME SMITH, MARY		5 PATIENT ADDRESS ANYWHERE		6 NY STATE		7 ZIP	
8 450000099999		9 123 MAIN STREET		10 NY 11299		11	
12 010118		13 30		14 010118		15 010118	
16 010118		17 010118		18 010118		19 010118	
20 24		21 4750.00		22		23	
24		25		26		27	
28		29		30		31	
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## Home Health Care Billing

### **Coding Requirements:**

Partners Health Plan requires that all providers contracted to Medicare Reimbursement submit a HIPPS (Health Insurance Prospective Payment System) Code (using revenue code 0023), CBSA Code (using value code 61) and Bill Type 32X or 34X on a UB-04 claim form or in the 837I format.

All other applicable home care coding for services, i.e. HCPCS codes and units on the line level, are also required.

If a provider contract stipulates Medicare Reimbursement, all claims should be submitted utilizing CMS Medicare Coding. If a service is determined to not be covered by Medicare it will then be reimbursed at a Medicaid rate (if available). Partners Health Plan will process and pay the claim to New York State Medicaid Reimbursement Methodology and indicate this using an appropriate EOB message.

EOB Code = MC                    ***Payment based on an alternate fee schedule (Medicaid)***

If a provider contract stipulates Medicare Reimbursement but you feel that it should be reimbursed as Medicaid or another contracted rate, please contact Provider Services at 1-855-747-5483.

### **Denial Messages:**

If contracted to Medicare Reimbursement and the claim lacks the required HIPPS Code along with additional coding requirements necessary to group and price the claim accordingly, a claim will be denied with the following message:

EOB Code = HIP                    ***Missing/Incomplete/Invalid HIPPS Rate Code***

CARC Value = 16                    ***Claim/service lacks information or has submission/billing error(s) which is needed for adjudication***

RARC Value = N471                    ***Missing/Incomplete/Invalid HIPPS Rate Code***

The most current listing of HIPPS Codes can be found at:

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/HomeHealthPPS/coding\\_billing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/HomeHealthPPS/coding_billing.html)

The following claim denial message indicates that a review of coding is required by the provider and a resubmission of the claim is necessary:

EOB Code = LI                    ***Claim/Service Lacks Information or has Submission/Billing Error(s) Which is Needed for Adjudication***

CARC Value = 16                    ***Claim/service lacks information or has submission/billing error(s) which is needed for adjudication***

Based upon the home care coding submitted on the claim possible reasons for this denial are as follows:

- 1) Medicare Billing: Ensure that all required data elements noted above are present as well as the Patient Status Code and correct Statement From/Through Date.
- 2) Medicaid Billing: Ensure that all correct revenue codes, HCPCS, Units, and Bill Type are on the claim.

If further clarification on the specific reason for this denial message on a claim, contact the Partners Health Plan Provider Services Department at 1-855-747-5483.

### **Value Code 61:**

Value Code 61 is required on all Medicare coded claims to indicate the CBSA (Core-Based Statistical Area) of where the service took place.

- 61 is defined as: Location where service is furnished
- Report on the UB-04 claim form in FL39 with the CBSA Number as the Value Amount. The CBSA Number should be reported as a dollar amount with two zeroes in the cents field.

The image shows a portion of a UB-04 claim form. The top left section contains the provider's name and address: "Partners Health Plan, P.O. Box 2151, Charleston, WV 25328". To the right, there are several columns for Value Codes. The first column is labeled "FL39 VALUE CODES AMOUNT" and contains the value "61000000". The second column is labeled "FL38 VALUE CODES AMOUNT" and is empty. The third column is labeled "FL37 VALUE CODES AMOUNT" and is empty. The fourth column is labeled "FL36 VALUE CODES AMOUNT" and is empty. Below these columns are other fields for "FL35", "FL34", "FL33", "FL32", "FL31", "FL30", "FL29", "FL28", "FL27", "FL26", "FL25", "FL24", "FL23", "FL22", "FL21", "FL20", "FL19", "FL18", "FL17", "FL16", "FL15", "FL14", "FL13", "FL12", "FL11", "FL10", "FL09", "FL08", "FL07", "FL06", "FL05", "FL04", "FL03", "FL02", "FL01", "FL00".

- The most current listing of CBSA by CCN can be found at:  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2016-Wage-Index-Home-Page.html>

### **Procedure Codes:**

The appropriate procedure codes must be submitted based upon a provider's contractual arrangement for reimbursement.

If contracted to receive a Medicare rate, then the Medicare accepted HCPCS codes must be submitted on the claim (i.e., G0156 Home Health Aide).

If contracted to receive a Medicaid rate, then the Medicaid accepted codes must be submitted on the claim (i.e., S9122 Home Health Aid – CNA Care).

### **Units:**

Claims must be billed in whole units. If partial units are submitted, they will be rounded to the nearest whole number for reimbursement purposes.

## Personal Care Services – Dates of Service 1/1/2018 & Greater

### Procedure Codes:

<b>Procedure Code</b>	<b>Level of Care</b>
S5130	PCS Level I
T1019	PCS Level II
T1020	PCS Level II – Live In

### Modifiers:

\*At this time PHP is only authorizing services with modifier U1.

#### **Level I**

<b>Modifier</b>	<b>Level of Care</b>
U1	PCS Level I – 15 minutes

#### **Level II**

<b>Modifier</b>	<b>Level of Care</b>
U1	PCS Level II – 15 minutes

\*No modifier is required for PCS Level II – Live In (single client)

### Units:

Requirements for units are dependent upon the procedure code being used when reporting personal care services.

- If billing with S5130 or T1019 (15 minute increments) each unit should represent 15 minutes. Partners Health Plan will not reimburse more than 13 hours per day when billing S5130 or T1019 unless the member has specifically obtained authorization for split shifts.
- If billing T1020 (live in care) each unit should represent one date of service as this code represents per diem care. If billed with greater than 1 unit of service per date it will be denied with the following EOB Code:

EOB Code = PC1

***Per Diem Services billed as greater than one unit per service date not payable. Please resubmit with correct unit(s).***

Claims must be billed in whole units.

### Claim Form:

Personal Care Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 580 should be used when submitting on a UB-04 claim form.

**Statement From and Through Dates:**

All dates must be entered in the format MMDDYYYY.

When billing for one date of service, enter the date as the FROM date and as the THROUGH date.

When billing for multiple service dates, enter the first service of the billing period as the FROM date and the last service date as the THROUGH date. The FROM/THROUGH dates should be in the same calendar month.

**Multiple Shifts/Same Service Date:**

When billing for multiple shifts on the same service date, all shifts must be billed on the same claim form. Each shift should be billed on a separate claim line.

\*If multiple shifts for same service date are billed on separate claims, they may result in a duplicate payment denial

**Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

\*If a claim is submitted with a modifier that differs from what was authorized the claim will be denied with the following EOB Code:

EOB Code = A4                    ***Not Authorized for Billed Level of Service***

## Personal Care Services – Dates of Service Prior to 1/1/2018

### **Modifiers:**

All Personal Care claims require a modifier be submitted to identify the level of care.

<b><i>Modifier</i></b>	<b><i>Level of Care</i></b>
U1	PCA Level 1 Care
U2	PCA Level 2 Care

In the absence of a modifier a claim will be denied to resubmit with the appropriate modifier with the following EOB Code:

EOB Code = MOD

***The procedure code is inconsistent with the modifier used or a required modifier is missing***

### **Units:**

Requirements for units are dependent upon the procedure code being used when reporting personal care services.

- If billing with T1019 (15 minute increments) each unit should represent 15 minutes. Partners Health Plan will not reimburse more than 13 hours per day when billing T1019 unless the member has specifically obtained authorization for split shifts.
- If billing T1020 (live in care) each unit should represent one date of service as this code represents per diem care. If billed with greater than 1 unit of service per date it will be denied with the following EOB Code:

EOB Code = PC1

***Per Diem Services billed as greater than one unit per service date not payable. Please resubmit with correct unit(s).***

Claims must be billed in whole units.

### **Claim Form:**

Personal Care Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 580 should be used when submitting on a UB-04 claim form.

### **Statement From and Through Dates:**

All dates must be entered in the format MMDDYYYY.

When billing for one date of service, enter the date as the FROM date and as the THROUGH date.

When billing for multiple service dates, enter the first service of the billing period as the FROM date and the last service date as the THROUGH date. The FROM/THROUGH dates should be in the same calendar month.

**Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

## CDPAS/CDPAP Services – Dates of Service 1/1/2018 & Greater

### **Procedure Codes:**

<b><i>Procedure Code</i></b>	<b><i>Level of Care</i></b>
T1019	CDPA
T1020	CDPA Live In

### **Modifiers:**

*\*At this time PHP is only authorizing services with modifier U6.*

All CDPAS/CDPAP claims require a modifier be submitted to identify the level of care.

<b><i>Modifier</i></b>	<b><i>Level of Care</i></b>
U6	CDPA - Basic

### **Units:**

Claims submitted with T1019 and the appropriate modifier will be reimbursed in quarter hour increments (15 minutes per unit).

CDPAS/CDPAP rates are available per hour and Partners Health Plan will divide the rate by 4 to determine ¼ increment.

### **Claim Form:**

CDPAS/CDPAP Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 580 should be used when submitting on a UB-04 claim form.

### **Statement From and Through Dates:**

All dates must be entered in the format MMDDYYYY.

When billing for one date of service, enter the date as the FROM date and as the THROUGH date.

When billing for multiple service dates, enter the first service of the billing period as the FROM date and the last service date as the THROUGH date. The FROM/THROUGH dates should be in the same calendar month.

**Multiple Shifts/Same Service Date:**

When billing for multiple shifts on the same service date, all shifts must be billed on the same claim form. Each shift should be billed on a separate claim line.

\*If multiple shifts for same service date are billed on separate claims, they may result in a duplicate payment denial

**Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

\*If a claim is submitted with a modifier that differs from what was authorized the claim will be denied with the following EOB Code:

EOB Code = A4                    ***Not Authorized for Billed Level of Service***

## CDPAS/CDPAP Services – Dates of Service Prior to 1/1/2018

### **Modifiers:**

All CDPAS/CDPAP claims require a modifier be submitted to identify the level of care.

<b><i>Modifier</i></b>	<b><i>Level of Care</i></b>
U6	Level 1 Care
U7	Level 2 Care
U8	Per Diem Care

In the absence of a modifier a claim will be denied to resubmit with the appropriate modifier with following EOB code:

EOB Code = MOD

***The procedure code is inconsistent with the modifier used or a required modifier is missing***

### **Units:**

Claims submitted with T1019 and the appropriate modifier will be reimbursed in quarter hour increments (15 minutes per unit).

CDPAS/CDPAP rates are available per hour and Partners Health Plan will divide the rate by 4 to determine ¼ increment.

### **Claim Form:**

CDPAS/CDPAP services are to be submitted on a UB-04 claim form or in the 837I format with the necessary data elements.

When submitting on a UB-04, there are specific rate codes required to support the CDPAS/CDPAP services.

2401 - CONSUMER DIRECT PERS ASSIST 1 CLIENT HOURLY

2402 - CONS DIRECT PERS ASSIST 2 OR > CLNTS HRLY PER CLNT

2403 - CONS DIR PERS ASSIST 1 CLNT HRLY ENHANCED RATE

2404 - CONS DIR PERS ASSIST 2 OR > CLNTS HRLY PER CLNT EN

2405 - CONSUMER DIRECT PERSONAL ASSIST 1 CLNT LIVE-IN

2406 - CONS DIR PERS ASSIST 2 OR > CLNTS PER CLNT LIVE-IN

2422 - CDPAP 1 CLIENT, QUARTER HOUR

2423 - CDPAP 2 CLIENTS, PER CLIENT, QUARTER HOUR

2424 - CDPAP 1 CLIENT, ENHANCED RATE, QUARTER HOUR

2425 - CDPAP 2 CLIENTS, PER CLIENT, ENHANCED RATE, QTR HR

Revenue Code 0580 should be submitted in FL42 with the number of units in FL46 when submitting on a UB-04.

**Statement From and Through Dates:**

All dates must be entered in the format MMDDYYYY.

When billing for one date of service, enter the date as the FROM date and as the THROUGH date.

When billing for multiple service dates, enter the first service of the billing period as the FROM date and the last service date as the THROUGH date. The FROM/THROUGH dates should be in the same calendar month.

**Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

## Adult Day Health Care Services – Dates of Service 1/1/2018 & Greater

Adult Day Health Care (ADHC) services include care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. ADHC includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

### Procedure Codes:

<b>Code</b>	<b>Definition</b>	<b>Units</b>
S5102	Day Care Service; Adult; per day	1 unit = one day

### Modifiers:

<b>Modifier</b>	<b>Level of Care</b>
U1	Basic Level
U2	Standard Level
U3	Intensive Level

### Claim Form:

ADHC Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 3103 should be used when submitting on a UB-04 claim form.

### Reimbursement:

ADHC services are reimbursed based on contracted rates. If the reimbursement indicates a percentage of NYS Medicaid it will be paid according to the most current published rate available from NYSDOH. If no rate is obtained or published the claim will be denied with the following EOB code:

EOB code = NA                      **No allowable amount**

### Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

\*If a claim is submitted with a modifier that differs from what was authorized the claim will be denied with the following EOB Code:

EOB Code = A4

**Not Authorized for Billed Level of Service**

**Transportation for ADHC Services:**

Non – emergent transportation services billed in combination with an ADHC claim are reimbursable if authorized regardless if it is individually specified in the provider contract. This service is generally billed through using the below procedure code:

Code	Definition	Units
T2003	Non-emergent transport; encounter/trip	1 unit = one way trip

**NOTE:** Transportation units are 1 unit per one-way trip. They are NOT based on mileage.

**Reimbursement:**

Transportation services are reimbursed based on contracted rates. If the contract does not include a specific rate for Transportation the services will be paid according to the most current published rate available from the NYSDOH Transportation fee schedule.

**ADHC Claim Lines Example:**

42 SERV CD	43 DESCRIPTION	44 RCPT DATE	45 APPR CODE	46 SERV DATE	48 SERV UNITS	47 TOTAL CHARGES	49 NON-COVERED CHARGES
3103	ADULT DAY CARE MED/SOC D	85102		020217	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		020217	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		020317	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		020317	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		020617	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		020617	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		020717	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		020717	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		020817	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		020817	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		021317	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		021317	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		021417	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		021417	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		021617	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		021617	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		021717	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		021717	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		022117	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		022117	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102		022217	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003		022217	1.0	42.42	

## Adult Day Health Care Services – Dates of Service Prior to 1/1/2018

Adult Day Health Care (ADHC) services include care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. ADHC includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

### **Code/Units:**

<b>Code</b>	<b>Definition</b>	<b>Units</b>
S5101	Day Care Services; Adult; per half day	1 unit = one half day
S5102	Day Care Service; Adult; per day	1 unit = one day

### **Claim Form:**

ADHC Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 3103 should be used when submitting on a UB-04 claim form.

### **Reimbursement:**

ADHC services are reimbursed based on contracted rates. If the reimbursement indicates a percentage of NYS Medicaid it will be paid according to the most current published rate available from NYSDOH. If no rate is obtained or published the claim will be denied with the following EOB code:

EOB code = NA                      ***No allowable amount***

### **Prior Authorization:**

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

**Transportation for ADHC Services:**

Non – emergent transportation services billed in combination with an ADHC claim are reimbursable if authorized regardless if it is individually specified in the provider contract. This service is generally billed through using the below procedure code:

<b>Code</b>	<b>Definition</b>	<b>Units</b>
T2003	Non-emergent transport; encounter/trip	1 unit = one way trip

**NOTE:** Transportation units are 1 unit per one-way trip. They are NOT based on mileage.

**Reimbursement:**

Transportation services are reimbursed based on contracted rates. If the contract does not include a specific rate for Transportation the services will be paid according to the most current published rate available from the NYSDOH Transportation fee schedule.

**ADHC Claim Lines Example:**

#1 REV CD	#2 DESCRIPTION	#3 HCPCS - RATE 1 - APPR CODE	#4 REV DATE	#5 REV UNITS	#6 TOTAL CHARGE	#7 REIMBURSED CHARGE
3103	ADULT DAY CARE MED/SOC D	85102	020217	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020217	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	020317	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020317	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	020617	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020617	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	020717	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020717	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	020817	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020817	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	021317	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021317	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	021417	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021417	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	021617	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021617	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	021717	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021717	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	022117	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	022117	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	85102	022217	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	022217	1.0	42.42	

## SNF (Skilled Nursing Facility) Billing

### **CODING REQUIREMENTS:**

- UB04 Claim form (basic required fields)
- Occurrence Span Code 70 (dates of qualifying hospital stay)
- Type of Bill 21X
- Revenue Code 0022 (indicates claim being paid to SNF PPS-used to report HIPPS Rate Code data)
- HIPPS Code
  - 5 digit code reported in the HCPCS/Rate/HIPPS field (FL44)
  - First 3 positions contain the RUG group, last 2 contain the assessment indicator code
  - HIPPS codes should be billed in order of which member received that level of care
  - Number of covered days for each HIPPS code in FL46
  - Total charges should equal \$0 for HIPPS line
- Room & Board Rev Code. PHP utilizes Code Set #2 from the NYS Medicaid SNF Billing Codes. Claims submitted with a Revenue Code other than Code Set #2 will be denied with EOB code **IC - INCORRECT REVENUE CODE. PLEASE RESUBMIT WITH VALID ROOM & BOARD REV CODE FROM CODE SET 2 OF THE NYS MEDICAID SNF GUIDELINES**
  - Custodial Care – 120
  - AIDS Specialty Unit – 160
  - Ventilator Specialty Unit – 101
  - Neurobehavioral Specialty Unit – 124
  - TBI Specialty Unit – 199
  - Pediatric Specialty Unit – 123
  - Bed Hold (Hospitalization) – 185
  - Bed Hold (Other Leave of Absence) – 183
  - Bed Hold (Therapeutic) – 189
  - Respite Care (Short Term) – 663
- CBSA Code (Core-Based Statistical Area)
- Treatment Authorization Code (max of 18 digits)

### **RESPITE CARE IN THE SNF SETTING:**

- Long Term Respite Services
  - Authorized as Rev Code 663
  - Rev Code Billed – 663
  - Covered as a Medicaid Waiver service
  - Reimbursed to current Medicaid Benchmark rate for facility
  - Not a covered benefit under Medicare
- Short Term Respite Services
  - Not part of Medicaid Waiver service
  - If approved is reimbursed to Medicaid Facility specific Rate (not published)
  - Medicare only covers under Hospice benefit plan of care (max of 5 days covered)

### MEDICAID RATES:

- Located here: [health.ny.gov/facilities/long\\_term\\_care/reimbursement/nhr/](http://health.ny.gov/facilities/long_term_care/reimbursement/nhr/)
- Use most current rates effective set file
- Under appropriate tab (Medicare Elig/Non-Medicare Elig/Specialty Non-Medicare/Specialty Medicare)

### HIPPS VALUES:

- Defined as Health Insurance Prospective Payment System code set
- Listing can be found here: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes>
- Effective 10/1/19, new classification model called Patient Driven Payment Model (PDPM). Guidelines and coding information can be found at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM>
- Claims for date of service 1/1/20 and forward must have a valid PDPM HIPPS code.
- Claims submitted with an old HIPPS code after date of service 1/1/20 will be denied with EOB code **PDG - HIPPS CODE INVALID EFFECTIVE 1/1/2020. PLEASE SUBMIT A VALID PDGM HIPPS CODE**

### RUGS VALUES:

- Defined as Resource Utilization Groups (version IV)
  - Rehabilitation plus Extensive Services
  - Ultra-High Rehabilitation
  - Very High Rehab
  - High Rehab
  - Medium Rehab
  - Low Rehab
  - Extensive Services
  - Special Care High
  - Special Care Low
  - Clinically Complex

### LEVEL OF CARE:

- When/if there is a change in the level of care authorized during an episode of care (billable month) the claim must be billed appropriately. Example below:  
**Approved 1/1/20 – 1/31/20 (Skilled level 1/1-1/15 and Custodial level 1/16-1/31)**
  - Claim submitted with valid SNF Inpatient coding for DOS 1/1/20 – 1/15/20 at Skilled level of care.
  - Claim submitted with valid SNF Custodial coding for DOS 1/16/20 – 1/31/20 with proper Room & Board Revenue Code.
- If claim is submitted with both levels of care on one claim it will be denied with EOB code **LOC - LEVEL OF CARE BILLED DOES NOT MATCH LEVEL OF CARE AUTHORIZED. PLEASE RESUBM IT WITH APPROPRIATE CODING**

## NDC Code Submission

### **Coding Requirements:**

The New York State Department of Health (NYSDOH) mandates that all Managed Care Plans must report National Drug Codes (NDCs) for all physician administered drugs.

All physician administered drugs, by all provider types, require a valid 11-digit NDC number and the applicable quantity and measurement. This includes all J-codes and all other applicable drug codes (i.e., chemotherapeutics, therapeutics, etc.)

### **Claim Form:**

The NDC information may be reported on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format, as applicable.

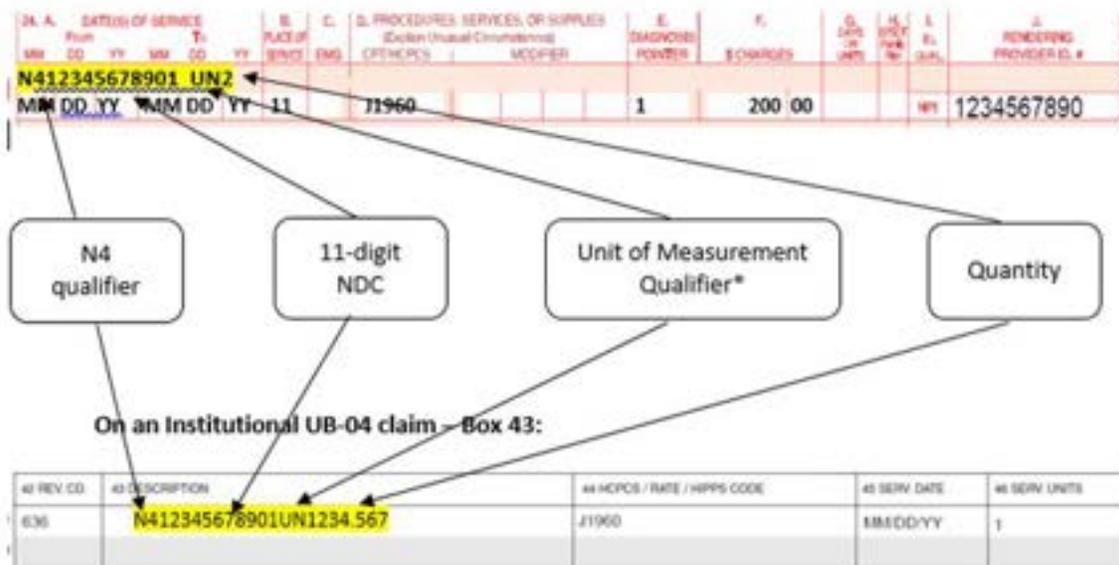
### **Electronic Submission:**

In either the 837I or 837P format providers must report the 11-digit NDC and its corresponding information, in addition to the procedure code, in the LIN segment of Loop ID 2410 to specify the physician-administered drug that is part of the service described in SV1 for the 837 format. Providers must also report the quantity and unit of measure of the NDC as outlined in the table below:

<b>LIN Segment – Drug Identification</b> i.e., LIN**N4*01234567891		
<b>LIN02</b>	<b>N4</b>	<b>N4 Qualifier identifies NDC being billed</b>
<b>LIN03</b>	<b>Actual NDC</b> i.e., 01234 5678 91	<b>Report NDC in the 11-digit format – do not use hyphens or spaces</b>
<b>CTP Segment – Drug Segment</b> i.e., CTP***2.50*2*UN		
<b>CTP03</b>	<b>Unit Price</b>	<b>i.e., 2.50</b>
<b>CTP04</b>	<b>Dispensing Quantity</b>	<b>i.e., 2</b>
<b>CTP05</b>	<b>Unit of Measure Value</b>	<b>F2 = International Unit GR = Gram ML = Milliliter UN = Unit ME = Milligram</b>

**Paper Claim Submission:**

On a Professional CMS-1500 claim – Box 24A (shaded area):



On an Institutional UB-04 claim – Box 43:

The following are the only acceptable values for submission as a Unit of Measurement Qualifier:

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

**Denial Messages:**

EOB Code **PA** identifies that you have submitted a procedure code which requires the NDC Code, Qualifier, and Units for which you did not submit any or all these data elements on your claim submission.

- EOB Code = PA                      ***NDC Code, qualifier and unit required***
- CARC = 204                        ***This service/equipment/drug is not covered under the patient's current benefit plan***
- RARC = M119                      ***Missing/incompleted/invalid/deactivated/withdrawn National Drug Code (NDC)***

You may resubmit your claim for payment as follows:

- On an Institutional UB-04 claim you should submit as a corrected claim, which is identified by utilizing the applicable Bill Type ending in '7' to designate as corrected (i.e., XX7, 137, 737, etc.)
- On a Professional CMS-1500 claim you should mark the claim as corrected and include the original claim number in Box 22 'Original Reference No.'

All resubmissions/corrected claims should include all original claim lines.

## Anesthesia Billing

### Coding Requirements:

Anesthesia services should be billed with the number of actual minutes in the units field (Item 24G) of the CMS-1500 form. The minutes will be divided by 15 minute increments and rounded to the nearest tenth to obtain the total anesthesia units. If the claim is submitted without the minutes in field 24G, the claim will be denied.

Services should be reported in the following format:

Paper claims should have the Start and End time of the anesthesia service in Box 19 of a CMS-1500 (see below example).

19. RESERVED FOR LOCAL USE <b>ANESTHESIA: 1810 – 2005 (115 MINUTES)</b>										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER													
24. A. DATE(S) OF SERVICE From To MM DD YY 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. EPID/ Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
06	07	07		22		00320	P1		90000	8		NPI	
												NPI	
												NPI	
												NPI	

Electronic claims should include the correct qualifier for the Units indicator.

Qualifier MJ = total minutes

### Denial Messages:

If a claim is missing the above information it will be denied with the following message:

EOB code = MT

***Missing/Incomplete/Invalid Anesthesia Time/Units***

CARC code = 16

***Claim/Service lacks information or has submission/billing error(s) which is needed for adjudication***

RARC code = N203

***Missing/Incomplete/Invalid Anesthesia Units***

### Procedure Codes:

When billing anesthesia please utilize CPT codes 00100-01999.

CPT codes 99100 (special anesthesia services) and 99140 (emergency anesthesia) are not separately reimbursed.

Do **NOT** bill general anesthesia using surgical CPT codes with anesthesia modifiers.

**Modifiers:**

- AA - Anesthesia Services performed personally by the anesthesiologist;
- AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures;
- G8 - Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures;
- G9 - Monitored anesthesia care for patient who has a history of severe cardiopulmonary condition;
- QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals;
- QS - Monitored anesthesia care service;
- QX - CRNA service; with medical direction by a physician;
- QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist;
- QZ - CRNA service: without medical direction by a physician; and
- GC - these services have been performed by a resident under the direction of a teaching physician.

The following modifiers are **NOT** covered by Medicare:

- P1 - A normal healthy patient
- P2 - A patient with mild systemic disease
- P3 - A patient with severe systemic disease
- P4 - A patient with severe systemic disease that is a constant threat to life
- P5 - A moribund patient who is not expected to survive without the operation
- P6 - A declared brain-dead patient whose organs are being removed for donor purposes
- 47 – Anesthesia by surgeon – Used to report regional or general anesthesia provided by the surgeon (Not covered by Medicare)

**Anesthesia formula for payment calculations:**

Base Units + Time Units x Conversion Factor = Anesthesia Fee Amount

**Example:**

CPT code 00810 (box 24D)

Minutes 45 (box 24G) \*Minutes will be converted to units for payment calculations; 15 minutes = 1 unit

Anesthesia time: 1500 – 1545 45 minutes (box 19)

Base units (per 2014 CMS Base Units)		<b>5</b>
	+	
Time Units (45/15=3)		<b>3</b>
	x	
Conversion Factor (2017 CMS CF File based on NYC/LI locality)		<b>25.12</b>
		<hr/>
Payment		<b>\$200.96</b>

The CMS conversion factors are update annually and can be found at:

<https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html>

Please note that the base units have remained unchanged since 2014.

**Provider:**

Claims are processed under the provider group record when applicable; NOT the individual anesthesiologist.

## APG Reimbursement

### **Claim Form:**

All claims for APG Reimbursement as per your contractual arrangements are to be submitted on a UB-04 claim form or in the 837I format.

### **APG Guidelines:**

Refer to [https://www.health.ny.gov/health\\_care/medicaid/rates/apg/](https://www.health.ny.gov/health_care/medicaid/rates/apg/) for APG specific claim submission requirements.

### **Rate Code:**

The Rate Code is to be entered in the Value Amount field with a Value Code of 24 (FL39-FL41).

Utilize the appropriate rate code for the setting of the service rendered and based upon the rate codes approved by New York State Medicaid for your entity.

### **Facility NPI:**

The facility NPI must be entered in FL56 in order to allow processing to APG reimbursement.

**APG Claim Layout Example:**

1 Facility Address 1 City, State Zip		2 Facility *required if different than Box 1 Pay to Address City, State Zip		3 INCL CMT #		4 Patient Control #		5 Type of bill XXX	
6 MEMBER NAME Member ID #		7 CURRENT ADDRESS Member Street Address		8 STATE MED #		9 Medical Record #		10 TTN #	
11 Member Last Name, First Name MI		12 Member City		13 State		14 Zip			
15 MEMBER DOB M/D		16 Admit Date Type		17 SOURCE		18 OCCURRENCE PERIOD THROUGH		19 OCCURRENCE PERIOD THROUGH	
20 OCCURRENCE DATE		21 OCCURRENCE DATE		22 OCCURRENCE DATE		23 OCCURRENCE PERIOD THROUGH		24 OCCURRENCE PERIOD THROUGH	
25		26 VALUE CODES AMOUNT		27 VALUE CODES AMOUNT		28 VALUE CODES AMOUNT			
29		30		31		32		33	
34 REVENUE CODE		35 PROCEDURE CODE & MODIFIER *if applicable		36 DATE OF SERVICE		37 UNITS		38 TOTAL CHARGES ### ##	
39		40		41		42		43	
44		45		46		47		48	
49		50		51		52		53	
54		55		56		57		58	
59		60		61		62		63	
64		65		66		67		68	
69		70		71		72		73	
74		75		76		77		78	
79		80		81		82		83	
84		85		86		87		88	
89		90		91		92		93	
94		95		96		97		98	
99		100		101		102		103	
104		105		106		107		108	
109		110		111		112		113	
114		115		116		117		118	
119		120		121		122		123	
124		125		126		127		128	
129		130		131		132		133	
134		135		136		137		138	
139		140		141		142		143	
144		145		146		147		148	
149		150		151		152		153	
154		155		156		157		158	
159		160		161		162		163	
164		165		166		167		168	
169		170		171		172		173	
174		175		176		177		178	
179		180		181		182		183	
184		185		186		187		188	
189		190		191		192		193	
194		195		196		197		198	
199		200		201		202		203	
204		205		206		207		208	
209		210		211		212		213	
214		215		216		217		218	
219		220		221		222		223	
224		225		226		227		228	
229		230		231		232		233	
234		235		236		237		238	
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464		465		466		467		468	
469		470		471		472		473	
474		475		476		477		478	
479		480		481		482		483	
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519		520		521		522		523	
524		525		526		527		528	
529		530		531		532		533	
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539		540		541		542		543	
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629		630		631		632		633	
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684		685		686		687		688	
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704		705		706		707		708	
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744		745		746		747		748	
749		750		751		752		753	
754		755		756		757		758	
759		760		761		762		763	
764		765		766		767		768	
769		770		771		772		773	
774		775		776		777		778	
779		780		781		782		783	
784		785		786		787		788	
789		790		791		792		793	
794		795		796		797		798	
799		800		801		802		803	
804		805		806		807		808	
809		810		811		812		813	
814		815		816		817		818	
819		820		821		822		823	
824		825		826		827		828	
829		830		831		832		833	
834		835		836		837		838	
839		840		841		842		843	
844		845		846		847		848	
849		850		851		852		853	
854		855		856		857		858	
859		860		861		862		863	
864		865		866		867		868	
869		870		871		872		873	
874		875		876		877		878	
879		880		881		882		883	
884		885		886		887		888	
889		890		891		892		893	
894		895		896		897		898	
899		900		901		902		903	
904		905		906		907		908	
909									

## FQHC Claims

FQHC claims processed to Medicare reimbursement may require a valid payment code on the encounter service line for each billed service date. This does not apply to claims processed to Medicaid reimbursement (i.e., rate code 4013).

### **FQHC Visit Codes:**

- G0466 FQHC visit, new patient - A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
- G0467 FQHC visit, established patient - A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
- G0468 FQHC visit, IPPE or AWV - A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
- G0469 FQHC visit, mental health, new patient - A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
- G0470 FQHC visit, mental health, established patient - A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare covered services that would be furnished per diem to a patient receiving a mental health visit.

### **Qualifying Visits:**

The qualifying visits that correspond to the specific payment codes, as per revised CMS guidance dated 12-06-17 are as follows:

<b><u>G0466:</u></b>	
	92002
	92004
	97802
	99201
	99202

99203  
99204  
99205  
99304  
99305  
99306  
99324  
99325  
99326  
99327  
99328  
99341  
99342  
99343  
99344  
99345  
99406  
99407  
99497  
G0101  
G0102  
G0108  
G0117  
G0118  
G0296  
G0442  
G0443  
G0444  
G0445  
G0446  
G0447  
G0490  
Q0091

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**G0467:**

92012  
92014  
97802  
97803  
99212  
99213  
99214  
99215  
99304  
99035  
99306  
99307  
99308  
99309  
9910

	99315
	99316
	99318
	99334
	99335
	99336
	99337
	99347
	99348
	99349
	99350
	99406
	99407
	99495
	99496
	99497
	G0101
	G0102
	G0108
	G0117
	G0118
	G0270
	G0296
	G0442
	G0443
	G0444
	G0445
	G0446
	G0447
	G0490
	Q0091
<b><u>G0468:</u></b>	G0402
	G0438
	G0439
<b><u>G0469:</u></b>	90791
	90792
	90832
	90834
	90837
	90839
	90845
<b><u>G0470:</u></b>	90791
	90792
	90832
	90834
	90837
	90839
	90845

\*Effective 1/1/18: When reporting HCPCS code G0511 or G0512 as a stand-alone visit a FQHC payment code is not required.

**Refer to the following link for additional guidance on the use of FQHC Payment Codes:**

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf>

**Claim Form:**

All claims are to be submitted on a UB-04 claim form or in the 837I format.

**Bill Type:**

Bill type 77X (i.e., 771) should be utilized for FQHC encounters.

**Revenue Code:**

The appropriate Revenue Code should be submitted as follows:

- Rev Code 052X (for payment codes G0466, G0467 or G0468)
- Rev Code 0519 or 0900 (for payment codes G0469 or G0470)

## Net Available Monthly Income (NAMI)

NAMI is determined by the member's local county Department of Social Services. This member will be required to pay this amount directly to the Skilled Nursing Facility (SNF) or Independent Care Facility (ICF).

### **Value Code:**

Value Code 23 should be used to indicate that the member's NAMI amount is entered as the Value Amount (FL39-41).

### **NAMI Submission:**

If billing occurs more than once a month, the full NAMI amount should be submitted on the first claim for the month. For example, when submitting an ICF claim with Rate Code 3822 daily. The claim dated as the 1<sup>st</sup> of the month should include the member's NAMI amount.

### **Reimbursement:**

The reimbursement of the claim will be reduced by the NAMI amount.

### **Claim Message:**

EOB Code = NAM      **Payment Reduced By Monthly NAMI Amount**

CARC Code = 142      ***Monthly Medicaid Patient Liability Amount***

## Corrected Claims

If a claim was submitted to and accepted by Partners Health Plan but was later found to have incorrect information, certain data elements on the claim can be corrected and/or added and the claim can be resubmitted. The resubmitted claim is a corrected claim. Examples of data elements that may be corrected and/or added are:

- Diagnosis Code
- Number of Units
- Date(s) of Service
- Procedure Code(s) and/or modifiers
- Place of Service (POS)
- Revenue Code
- Total Charges
- Rate Code (full day vs. half day)

Corrected Claims should include all claim lines from original claim unless removal of a line is due to the service not being rendered. **Failure to include all original claim lines may result in claim denial or takeback.**

### **UB-04 Institutional Claim Form:**

Corrected claims can be submitted either electronically via EDI transaction or manually via paper claim form.

EDI corrected claims submitted on an 837I transaction must be in the following data file format:

- The claim type (segment CLM05-03) must be a '7'.

Manual UB-04 claim forms should:

- List the number '7' in the third digit of the bill type in FL4.

	4	TYPE OF BILL
		137
D H	7	

### **CMS-1500 Professional Claim Form:**

Corrected claims must be submitted manually via paper claim form. If submitted electronically it may result in your claim being denied as a duplicate.

CMS-1500 claim forms should be marked as "CORRECTED CLAIM" and in addition you may reference the original claim number, as shown in the three examples below.



You can also mark the claim with resubmission code 7 in Box 22 and include the original claim number in Box 22 'Original Reference No'.

Corrected claims (XX7) are assigned a new claim number upon receipt. The original claim will be reversed, and a full takeback of the claim payment will occur. The corrected claim will be processed and paid accordingly.

*Example corrected claim paper remit:*

**Example of paper remit:**

Date of Service	Code or Description	Total Charge	Discount	Other Plan Payment	Other Adjustment	Allowed Amount	Patient Responsibility			Payment Amount	Explanation Codes
							Co-Ins	Co-Pay	Deductible		
12/01/21-12/03/21	0300	106.00	0.00	0.00	106.00	0.00	0.00	0.00	0.00	0.00	0300PH X7PH
12/01/21-12/03/21	0301	317.00	0.00	0.00	317.00	0.00	0.00	0.00	0.00	0.00	0301PH X7PH
12/01/21-12/03/21	0301	290.00	0.00	0.00	275.94	14.06	0.00	0.00	0.00	14.06	0301PH X7PH
12/01/21-12/03/21	0301	188.00	0.00	0.00	188.00	0.00	0.00	0.00	0.00	0.00	0301PH X7PH
12/01/21-12/03/21	0301	297.00	0.00	0.00	297.00	0.00	0.00	0.00	0.00	0.00	0301PH X7PH
12/01/21-12/03/21	0301	553.00	0.00	0.00	553.00	0.00	0.00	0.00	0.00	0.00	0301PH X7PH

Explanations		
Administered by	Code	Description
HealthSmart Benefit Solutions	035PH	NOT RECOGNIZED BY OPSS ON BILL TYPE 12X, 13X OR 14X; AN ALTERNATE CPT-BCPCS CODE MAY BE AVAILABLE

**X7PH CORRECTED CLAIM PROCESSED FOR ADDITIONAL PAYMENT**

**Voided Claims:**

If a claim processed by Partners Health Plan was later determined was a service that did not occur, you may submit a voided UB-04/837I transaction by submitting the following:

EDI voided claims submitted on an 837I transaction must be in the following data file format:

- The claim type (segment CLM05-03) must be a '8'.

Manual UB-04 claim forms should:

- List the number '8' in the third digit of the bill type in FL4.

Upon receipt of a voided claim, a takeback will occur in a future check run cycle. A takeback will be applied to the original claim and the XX8 voided claim submission will be processed and denied with EOB code R8.

Example voided claim paper remit:

Total: 0.00											
Provider: [REDACTED]			Patient Acct # : [REDACTED]			Group/Check Number: [REDACTED]					
Network: [REDACTED]			Member Number: [REDACTED]			Group Name: PARTNERS HEALTH PLAN					
Patient Name: [REDACTED]			Claim Number: 366698			Customer Service #: 1-855-747-5483					
12/04/25-12/14/25	4437	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	RSPH
Total:		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Provider: [REDACTED]			Patient Acct # : [REDACTED]			Group/Check Number: [REDACTED]					
Network: [REDACTED]			Member Number: [REDACTED]			Group Name: PARTNERS HEALTH PLAN					
Patient Name: [REDACTED]			Claim Number: 366698			Customer Service #: 1-855-747-5483					
12/17/25-12/17/25	4437	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	RSPH
Total:		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Provider: [REDACTED]			Patient Acct # : [REDACTED]			Group/Check Number: [REDACTED]					
Network: [REDACTED]			Member Number: [REDACTED]			Group Name: PARTNERS HEALTH PLAN					
Patient Name: [REDACTED]			Claim Number: 366699			Customer Service #: 1-855-747-5483					
05/01/25-05/01/25	4437	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	RSPH
Total:		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

**Explanations**

Administered by	Code	Description
HealthSmart Benefit Solutions	ANSIO	Charge exceeds fee schedule (maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
	MIRPH	INVALID OR MISSING REQUIRED VALUE CODE/RATE CODE FOR CLAIM PROCESSING PLEASE RESUBMIT.
	RSPH	VOIDED CLAIM PROCESSED, OVERPAYMENT IDENTIFIED
	SCPH	PAID ABOVE SUBMITTED CHARGE(S)

Example original claim takeback corrected and/or voided claim paper remit:

Payment Adjustments		
Reference ID	Adjustment Type	Adjustment Amount
PLB3843365	Overpayment Recovery	\$(303.24)
PLB3843367	Overpayment Recovery	\$(300.31)
		<b>TOTAL: \$(603.55)</b>

NOTE-001

UE CLAIM NUMBER - 0003843365 - VOIDED CLAIM PROCESSED, OVERPAYMENT IDENTIFIED

- Note will reflect reason for the takeback

Example original claim takeback corrected and/or voided claim 835 electronic remit:

Payment adjustments are reflected in the PLB segment as follows -

PLB\*999999999\*20221231\*WO:ID 4500009999999-00 PA B9999I999999 DOS 20220608\*303.24~

PLB\*999999999\*20221231\*WO:ID 4500009999999-00 PA B9999I999998 DOS 20220621\*300.31

**Late Charges:**

PHP will not process the claims reporting late charges (bill type XX5). Claims are expected to be resubmitted as a corrected claim including all claim lines. Claims submitted with a bill type XX5 will be denied with EOB Code: X5.

## Unidentified Claim Returns

If a paper claim submission is received but is unable to be processed into the claims processing system, it will be returned to the provider.

To ensure a claim can be loaded successfully for processing please include the following:

- Participant's Full Name
- Participant's Date of Birth
- Participant's Correct Address
- Participant's Member Identification Number (as presented on the Member's ID Card)

The most common reason for claims to be returned as "Unidentified" is due to a discrepancy in the date of birth submitted on the claim form.

## UNIDENTIFIED CLAIM RETURN LETTER

The enclosed claim was received by our office for processing. Based on the information provided, we are unable to process this claim.

The claim(s) could not be processed because:

### REASON

As a reminder, to ensure prompt service from **Partners Health Plan**, please provide the following information on all claims submitted:

- Participant's Full Name & Patient's Full Name (if different from Participant)
- Participant's Date of Birth
- Participant's Correct Address
- Social Security Number/ Identification Number provided by group plan ID card.
- Group Name & Group Number

This information is necessary for us to process your claim(s) both promptly and accurately.

**Additionally, please note that for the most expedited processing, it is best to submit claims electronically per the instructions on the Participant's ID card.**

We greatly appreciate your assistance.

Please correct the issue(s) referenced above and resubmit the claim to the appropriate address.

Thank you for your cooperation.

Mail Services Department

## Zelis Editing

Partners Health Plan uses correct coding software provided by Zelis.

All PHP professional claims are currently audited by Zelis.

If the claim is edited and the procedure is denied based upon correct coding logic the claim line will be denied and an applicable EOB code/message will be applied to the claim line.

The following is a list of possible EOB codes for Zelis denials:

<b><u>EOB Code</u></b>	<b><u>EOB Code Description</u></b>
• Z01	PROCEDURE CODE IS OBSOLETE
• Z02	PROCEDURE IS WITHIN THE GLOBAL FEE PERIOD OF AN EXPERIMENTAL PROCEDURE
• Z03	PROCEDURE IS CONSIDERED EXPERIMENTAL
• Z04	PROCEDURE IS WITHIN THE GLOBAL FEE PERIOD OF A COSMETIC PROCEDURE
• Z05	PROCEDURE IS CONSIDERED COSMETIC OR DISCRETIONARY
• Z06	CO-SURGEON/TEAM SURGERY INAPPROPRIATE
• Z07	INAPPROPRIATE USE OF MODIFIER
• Z08	ALREADY PAID IN PART OR FOR THE GLOBAL AMOUNT ON ANOTHER CLAIM/PROVIDER
• Z09	ADD-ON CODE. PRIMARY PROCEDURE NOT FOUND
• Z10	NOT ALLOWED SEPARATE PAYMENT WITH PROCEDURE
• Z11	INCIDENTAL TO PROCEDURE/SERVICE AND IS BUNDLED. NO SEPARATE PAYMENT WARRANTED
• Z12	ASSISTANT SURGERY NOT APPROPRIATE
• Z13	IN GLOBAL FEE PERIOD OF PROCEDURE
• Z13	IN GLOBAL FEE PERIOD OF PROCEDURE
• Z14	TOO MANY NEW PATIENT CODES. REBILL AS ESTABLISHED PATIENT
• Z15	INAPPROPRIATELY BILLED INITIAL ADMISSION/DISCHARGE FACILITY VISIT CODES
• Z16	TOO MANY ICU VISITS ON SAME SERVICE DATE
• Z17	OTHER OFFICE VISIT ON SAME SERVICE DATE
• Z18	INAPPROPRIATE USE OF HCPCS CODE. CPT CODE EXISTS
• Z19	NOT ALLOWED PAYMENT WITH PROCEDURE
• Z20	NOT WITHIN MEDICAL PROTOCOL. DIAGNOSIS DOES NOT QUALIFY PROCEDURE OR FREQUENCY OF PROCEDURE
• Z21	EXCEEDS CLINICAL GUIDELINES

• Z22	AMBULANCE CHARGE DENIED DUE TO LACK OF MEDICAL NECESSITY
• Z23	LABORATORY CHARGE DENIED DUE TO LACK OF MEDICAL NECESSITY
• Z24	REBUNDLED WITH OTHER PROCEDURE(S)
• Z25	PAYMENT REDUCED AS SECONDARY PROCEDURE
• Z26	PAYMENT REDUCED BASED ON MODIFIER
• Z27	UNLISTED CPT CODE
• Z28	REBUNDLED WITH OTHER PROCEDURE(S)
• Z29	AS PER NCCI, SEPARATE PAYMENT NOT ALLOWED WITH COMPREHENSIVE PROCEDURE
• Z30	AS PER NCCI, MUTUALLY EXCLUSIVE
• Z31	NON-COVERED PROCEDURE/SERVICE
• Z32	TOO MANY PROCEDURES OF THIS TYPE BILLED
• Z33	DUPLICATE PROCEDURE
• Z34	PROCEDURE IS INCONSISTENT WITH THE PATIENT'S AGE
• Z35	PROCEDURE IS INCONSISTENT WITH THE PATIENT'S GENDER
• Z36	DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
• Z37	DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER
• Z38	PROCEDURE NOT COMPATIBLE WITH DIAGNOSIS
• Z39	AS PER NCCI PTP, SEPARATE PAYMENT NOT ALLOWED.
• Z40	INCOMPLETE DIAGNOSIS CODE

## FinThrive

FinThrive is the software utilized to price claims to Medicare reimbursement methodology.

Some of the correct coding modules within the FinThrive software are also utilized.

If the claim is edited and the procedure is denied based upon nThrive logic the claim line will be denied and an applicable EOB code/message will be applied to the claim line.

Information EOB codes/messages will also be applied based upon reimbursement methodology.

The following is a list of possible denial and information EOB codes for nThrive pricing and/or denials:

<b><u>EOB Code</u></b>	<b><u>EOB Code Description</u></b>
• MR	PRICED PER MEDICARE REIMBURSEMENT METHODOLOGY
• LCD	NON-COVERED CHARGES. THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD).
• NCD	NON-COVERED CHARGES. THIS DECISION WAS BASED ON A NATIONAL COVERAGE DETERMINATION (NCD).
• MIH	APC PRICING REQUIRES A HCPCS CODE TO PRICE
• 001	CODE IS BUNDLED
• 002	MODIFIER REQUIRED
• 004	ESRD MODIFIER ISSUE
• 005	REVENUE CODE NOT ALLOWED
• 006	CHARGES NOT ALLOWED
• 007	CPT CODE 90999 REQUIRES A G MODIFIER
• 008	NO APC FOUND
• 009	APC DELETED
• 010	CPT CODE NOT FOUND
• 011	CPT DELETED
• 012	NOT CPT AND REVENUE CODE 278 FOUND
• 013	NO CPT ON LINE
• 014	NOT PAID BY MEDICARE
• 016	NO CMG FOUND
• 017	CMG NOT ZERO
• 018	NO DRG FOUND
• 019	INVALID DRG
• 020	CONDITION CODE 20 OR 21 NOT PAID BY MEDICARE
• 021	MANDATORY CPT CODE
• 022	NOT PAID BY MEDICAID

• 023	THIS CPT CODE/MODIFIER WAS NOT FOUND IN THE PHYSICIAN FEE SCHEDULE
• 024	NO RVU DATA
• 025	NO ENDOSCOPY BASE RATE FOUND
• 026	CPT CODE MISSING
• 027	NO ANESTHESIA CODE FOUND
• 028	NO POST OP CARE ON 1500 OR BAD FORMAT
• 029	DIAGNOSIS NOT PAID
• 030	EXCEEDED MAXIMUM LINE COUNT
• 031	NO PHYSICIAN CODE WAS ON UB
• 032	NOT COVERED
• 072	CLAIM UNGROUPABLE BY MEDICARE REPRICER
• 035	NOT RECOGNIZED BY OPPTS ON BILL TYPE 12X, 13X, OR 14X; AN ALTERNATE CPT/HCPCS CODE MAY BE AVAILABLE.
• 036	INPATIENT PROCEDURE, ONLY; ADMIT PATIENT, BILL AS INPATIENT
• 037	DELETED CODE; NOT PAID UNDER MEDICARE
• 038	DELETED/DISCOUNTED CODE; NO PAYMENT MADE
• 039	NOT-COVERED (OR UNUSED) CODE
• 041	CURRENT DRUG OR BIOLOGICAL PAID UNDER TRANSITIONAL PASS-THROUGH
• 044	BRACHYTHERAPY SOURCE PAID SEPARATELY WHEN PROVIDED INTEGRAL TO SURGICAL PROCEDURE ON ASC LIST; PAYMENT CONTRACTOR-PRICED
• 046	NOT VALID FOR MEDICARE PURPOSES, NOT SUBJECT TO 90 DAY GRACE PERIOD
• 047	NEW DRUG OR BIOLOGICAL PAID UNDER TRANSITIONAL PASS-THROUGH (FORMER)
• 048	OPPTS PASS-THROUGH DEVICE PAID SEPARATELY WHEN PROVIDED INTEGRAL TO A SURGICAL PROCEDURE ON ASC LIST; PAYMENT CONTRACTOR-PRICED.
• 050	NON PASS-THROUGH DRUG/BIOLOGICAL
• 055	ITEMS AND SERVICES NOT BILLABLE TO THE FISCAL INTERMEDIARY
• 056	SERVICES OR PROCEDURES INCLUDED IN THE APC RATE, BUT NOT PAID SEPARATELY. (THIS IS A PACKAGED ITEM)
• 057	PACKAGED SERVICE/ITEM; NO SEPARATE PAYMENT MADE.
• 058	PAID ONLY IN PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS AND UNDER MENTAL HEALTH
• 065	CLINIC OR EMERGENCY DEPARTMENT VISIT; MAY INCLUDE ER PHYSICIAN OR PERSONAL PHYSICIANS

<ul style="list-style-type: none"> <li>• 066</li> </ul>	STATUTORY EXCLUSION, CODE REPRESENTS AN ITEM/SERVICE NOT IN THE STATUTORY DEFINITION OF PHYSICIAN SERVICES
<ul style="list-style-type: none"> <li>• 067</li> </ul>	NON-IMPLANTABLE DME; NOT PAID UNDER OPPTS. MUST BE BILLED TO DMERC.
<ul style="list-style-type: none"> <li>• 065</li> </ul>	CLINIC OR EMERGENCY DEPARTMENT VISIT; MAY INCLUDE ER PHYSICIAN OR PERSONAL PHYSICIANS

For more information regarding an NCD or LCD denial, you may utilize the following link as a resource:  
<https://www.cms.gov/medicare-coverage-database/search.aspx>

## Provider Quick Reference Guide

Link to FAQ & Quick Reference Guide:

[Provider FAQ & Quick Reference Guide - Partners Health Plan](#)

## Office Laboratory

### **CLIA (Clinical Laboratory Improvement Act) Billing**

The CLIA mandates that virtually all laboratories, including physician office laboratories (POLs), meet applicable Federal requirements and have a CLIA certificate in order to receive reimbursement from Federal programs. CLIA also lists requirements for laboratories performing only certain tests to be eligible for a certificate of waiver or a certificate for Physician Performed Microscopy Procedures (PPMP). The CLIA number must be included on each claim billed on the ASC X12 837 professional format or Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA.

All laboratory testing sites must have either a CLIA certificate of waiver, certificate for provider performed microscopy procedures, certificate of registration, certificate of compliance, or certificate of accreditation to legally perform clinical laboratory testing on specimens from individuals in the United States. The Food and Drug Administration approves CLIA waived tests on a flow basis. The CMS identifies CLIA waived tests by providing an updated list of waived tests to the A/B MACs (A) and (B) on a quarterly basis via a Recurring Update Notification. To be recognized as a waived test, some CLIA waived tests have unique HCPCS procedure codes and some must have a QW modifier included with the HCPCS code. For a list of specific HCPCS codes subject to CLIA see <https://www.cms.gov/files/document/mm13024-hcpcs-codes-clinical-laboratory-improvement-amendments-edits-april-2023.pdf>

The HCPCS codes that are considered a laboratory test under CLIA change each year. The CMS identifies the new HCPCS (non-waived, non-provider performed procedure) codes, including any modifiers that are subject to CLIA edits by providing an updated listing of these tests to the A/B MACs (A) and (B) on an annual basis via a Recurring Update Notification. A facility that submits a claim for any test mentioned in the HCPCS codes that are subject to CLIA edits list must have either a valid, current CLIA certificate of registration (certificate type 9), a CLIA certificate of compliance (certificate type 1), or a CLIA certificate of accreditation (certificate type 3). For a list of the specific HCPCS codes subject to CLIA edits refer to the following Internet site: <https://www.cms.gov/files/document/mm13024-hcpcs-codes-clinical-laboratory-improvement-amendments-edits-april-2023.pdf>

In addition, this document lists HCPCS codes in the 80000 series that are excluded from CLIA edits by providing an updated listing of these tests to the A/B MACs (A) and (B) on an annual basis via a Recurring Update Notification. No CLIA certificate is required for a claim submitted for any test mentioned in the HCPCS codes in the 80000 series that are excluded from CLIA edits list.

100 - CPT Codes Subject to and Not Subject to the Clinical Laboratory Fee Schedule (Rev. 1, 10-01-03) HO-437, A3-3628, B3-5114.1 For fee schedule purposes, clinical laboratory services include most laboratory tests listed in codes 80048-89399 of CPT-1996. The CMS issues an update to the laboratory fee schedule each year, with information about whether prices have been determined by CMS or whether the individual A/B MAC (B) must determine the allowable charge. Codes not included are not paid under the laboratory fee schedule but may be paid under the MPFS if covered for Medicare.

Q&A

1. Do all labs done on site require a CLIA number even if they are not below? **Yes.**
2. Do you require the QW modifier and the CLIA number for these CPT codes? **All waived tests require modifier QA.**
3. The below tests are the ones that require a CLIA waiver (CLIA certificate). Should these be billed with a CLIA number on claim? **Yes.**

<input type="checkbox"/> Adenovirus	<input type="checkbox"/> Drugs of Abuse	<input type="checkbox"/> Nicotine
<input type="checkbox"/> Aerobic/Anaerobic Organisms-Vaginal	<input type="checkbox"/> Erythrocyte Sedimentation Rate (ESR)	<input type="checkbox"/> Occult Blood
<input type="checkbox"/> Alanine Aminotransferase (ALT)	<input type="checkbox"/> Ethanol	<input type="checkbox"/> Ovulation Tests
<input type="checkbox"/> Albumin	<input type="checkbox"/> Follicle Stimulating Hormone (FSH)	<input type="checkbox"/> pH
<input type="checkbox"/> Alkaline Phosphatase (ALP)	<input type="checkbox"/> Gamma Glutamyl Transferase (GGT)	<input type="checkbox"/> Phosphorous
<input type="checkbox"/> Amylase	<input type="checkbox"/> Glucose	<input type="checkbox"/> Platelet Aggregation
<input type="checkbox"/> Aspartate Aminotransferase (AST)	<input type="checkbox"/> Glycosylated Hemoglobin	<input type="checkbox"/> Potassium
<input type="checkbox"/> B-Type Natriuretic Peptide (BNP)	<input type="checkbox"/> HDL Cholesterol	<input type="checkbox"/> Pregnancy Test (Urine)
<input type="checkbox"/> Bacterial Vaginosis, Rapid	<input type="checkbox"/> Helicobacter Pylori	<input type="checkbox"/> Protime
<input type="checkbox"/> Bladder Tumor Associated Antigen	<input type="checkbox"/> Hematocrit	<input type="checkbox"/> RSV (Respiratory Syncytial Virus)
<input type="checkbox"/> Blood Urea Nitrogen (BUN)	<input type="checkbox"/> Hemoglobin	<input type="checkbox"/> Saliva Alcohol
<input type="checkbox"/> Breath Alcohol (FDA OTC Devices Only)	<input type="checkbox"/> HCV, Rapid	<input type="checkbox"/> Sodium
<input type="checkbox"/> Calcium	<input type="checkbox"/> HIV, Rapid	<input type="checkbox"/> Strep A Test (Rapid)
<input type="checkbox"/> Calcium, Ionized	<input type="checkbox"/> Influenza	<input type="checkbox"/> Thyroid-Stimulating Hormone (TSH)
<input type="checkbox"/> Carbon Dioxide	<input type="checkbox"/> Ketones	<input type="checkbox"/> Total Bilirubin
<input type="checkbox"/> Catalase (Urine)	<input type="checkbox"/> Lactic Acid (Lactate)	<input type="checkbox"/> Total Protein
<input type="checkbox"/> Chloride	<input type="checkbox"/> LDL Cholesterol	<input type="checkbox"/> Trichomonas, Rapid
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Lead	<input type="checkbox"/> Triglycerides
<input type="checkbox"/> Creatine Kinase (CK)	<input type="checkbox"/> Microalbumin	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Creatinine	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Other: _____

Source:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf>

<https://www.cms.gov/medicare/quality/clinical-laboratory-improvement-amendments>

## Document Updates

DATE	UPDATE	DESCRIPTION	SECTION
1/6/2017	New	Version 1.0	
3/30/2017	Update	Version 2.0	Cover Page
3/30/2017	New Section	Adult Day Health Care Services	Adult Day Health Care Services
3/30/2017	Update	ICD-10 Diagnosis R69 for OPWDD Services	Office for People with Developmental Disabilities (OPWDD) Services
3/30/2017	Update	Semi Monthly Date Range	Supportive IRA Services
3/30/2017	New Section	Community Habilitation Services	Community Habilitation Services
3/30/2017	Update	Personal Care – Use of procedure codes and units	Personal Care Services
3/30/2017	Update	Data Requirement Corrected Claims	Corrected Claims
3/30/2017	Update	Calendar Year Spanning Benefit Years	General Submission Guidelines
3/30/2017	New Section	UFO Claim Returns/DOB Discrepancies	Unidentified Claim Returns
3/30/2017	Update	Claim form examples added to all OPWDD Services	
3/30/2017	Update	Additional FQHC guidance	FQHC Claims
6/9/2017	Update	Version 2.1	Cover Page
6/9/2017	Update	Paper Claims – Mailing Address	General Claims Submission Guidelines
7/31/2017	Update	Version 3.0	Cover Page
7/31/2017	New Section	Day Habilitation Services	Day Habilitation Services
7/31/2017	New Section	ICF	ICF
7/31/2017	Update	Self-Directed Services – Rate Code at header level	Self-Directed Services
7/31/2017	Update	Revised mailing address on Member ID Card	General Claims Submission Guidelines
7/31/2017	Update	Revised mailing address on EOB example	General Billing Guidelines
7/31/2017	Update	Valid Admit Types, Admit Sources, Bill Types	General Claims Submission Guidelines
7/31/2017	Update	Clearinghouse, EFT, 835 Information	General Claims Submission Guidelines
7/31/2017	New Section	Claim Check Editing	Claim Check Editing
7/31/2017	New Section	MedAssets	MedAssets
7/31/2017	Update	Pay to Name qualifier - 77	UB-04 Claim Form Crosswalk to 837I EDI Layout

1/1/2018	Update	Version 4.0	Cover Page
1/1/2018	Update	Revised Change Healthcare telephone number	General Claims Submission Guidelines
1/1/2018	New Section	Provider Quick Reference Guide	Provider Quick Reference Guide
1/1/2018	Change	<ul style="list-style-type: none"> <li>• Effective Dates</li> <li>• Statement From &amp; Through Dates</li> </ul>	Personal Care Services
1/1/2018	New	<ul style="list-style-type: none"> <li>• New Billing Codes 1/1/18</li> <li>• Statement From &amp; Through Dates</li> </ul>	Personal Care Services
1/1/2018	Change	<ul style="list-style-type: none"> <li>• Effective Dates</li> <li>• Statement From &amp; Through Dates</li> </ul>	CDPAS/CDPAP Services
1/1/2018	New	<ul style="list-style-type: none"> <li>• New Billing Codes 1/1/18</li> <li>• Statement From &amp; Through Dates</li> </ul>	CDPAS/CDPAP Services
1/1/2018	Change	<ul style="list-style-type: none"> <li>• Effective Dates</li> </ul>	ADHC Services
1/1/2018	New	<ul style="list-style-type: none"> <li>• New Billing Codes 1/1/18</li> </ul>	ADHC Services
1/1/2018	Update	Rate Codes, Submission Guidelines and Inquiries	Self-Directed Services
5/1/2018	Update	ID Card – New Logo	General Claim Submission Guidelines
5/1/18	Update	Explanation of Benefits Example – New Logo	General Billing Guidelines
5/1/18	Update	Updated Billing Codes	Respite Services
10/18/18	Change	Claim Form Example	Respite Services
10/18/18	Change	Transportation Units Note	ADHC Services
10/18/18	Change	Remove reference to denial EOB Code BG	Personal Care Services
10/18/18	Change	Remove reference to denial EOB Code BG	CDPAS/CDPAP Services
10/18/18	Change	Remove reference to denial EOB Code BG	ADHC Services
10/18/18	Update	Units	Home Health Care Billing
10/18/18	Update	Units	Community Habilitation Services
10/18/18	Update	Units	General Billing Guidelines
10/18/18	Update	FQHC Coding	FQHC Claims
10/18/18	Change	Voided Claims	Corrected Claims
2/28/19	Update	Updated Electronic Funds Transfer (EFT) enrollment and contact information	General Claims Submission Guidelines
3/19/19	Change	Add credit card payment information	General Claims Submission Guidelines
5/21/19	Update	Added CareVu EDI FAQ's	General Claims Submission Guidelines
5/21/19	Update	Added Zelis ePayment steps	General Claims Submission Guidelines
12/18/19	Update	Updated EOB Code – Changed to Zelis	Zelis Editing
12/18/19	Update	Change from MedAssets to nThrive	nThrive

12/31/19	Update	Removal of Lower of Reimbursement	General Claims Submission Guidelines
12/31/19	Update	Link to EDI Enrollment Packet	General Claims Submission Guidelines
1/2/2020	Update	Link to OPWDD Rate Codes	Office for People with Developmental Disabilities (OPWDD) Services
01/03/2020	Update	Member ID Card Example	General Claims Submission Guidelines
3/27/2020	New Section	CFCO Benefits Effective 1/1/2020	CFCO Benefits
3/27/2020	Update	Retroactive Rate Updates	Office for People with Developmental Disabilities (OPWDD) Services
3/30/2020	New	CMS link - NCD/LCD Denials	nThrive
3/30/2020	New	Claim Appeal Guidelines	Claim Appeal Guidelines
3/31/2020	New Section	SNF Billing Guidelines	SNF (Skilled Nursing Facility) Billing
12/22/2020	Delete	Remove section on CFCO Benefits due to delay in implementation until 2022	CFCO Benefits
12/22/2020	Update	Member ID Card Example – Revision effective 1/1/2021	General Claims Submission Guidelines
12/22/2020	Update	Provider Billing Address Updates– Delegated Providers	General Claims Submission Guidelines
12/22/2020	Update	Remove Provider Relations phone number	Provider Quick Reference Guide
12/23/2020	Update	Corrected and voided claims processing	Corrected Claims
12/23/2020	Update	Supervised IRA Medical Leave	Supervised IRA
9/1/2021	New Section	Office Labs and CLIA	Office Laboratory
9/1/2021	Updated	FQHC Claims	FQHC Claims
1/1/2022	Updated	Member ID Card Example – Revision effective 1/1/2022	General Claim Submission Guidelines
3/31/2022	New Section	Provider Portal Claim Form Submission	HealthSmart PHP myTPA Provider Portal Claim Submission
3/31/2022	Update	Availity EDI Clearinghouse	General Claim Submission Guidelines
3/31/2022	Update	ECHO Health	General Claim Submission Guidelines
3/31/2022	Delete	Zelis Epayment Enrollment Process	General Claim Submission Guidelines
3/31/2022	Update	Electronic Funds Transfer (EFT) and/or Credit Card Payments	General Claim Submission Guidelines
6/13/2022	Update	Responses to ERA questions	CareVu

6/13/2022	Update	837 Electronic Claim Submissions	General Claim Submission Guidelines
6/21/2022	Update	Link to EDI Enrollment Packet	General Claims Submission Guidelines
10/26/2022	Update	Provider Quick Reference Guide	Provider Quick Reference Guide
11/16/2022	Update	Links	Provider Quick Reference Guide
11/16/2022	Update	EDI Enrollment Packet – Link	General Claim Submission Guidelines
12/19/2022	Update	Member ID Card Example – Revision effective 1/1/2023	General Claim Submission Guidelines
01/03/2023	Update	Link to OPWDD Rate Code	Office for People with Developmental Disabilities (OPWDD) Services
03/06/2023	Update	Corrected Claim Submission	Corrected Claims
03/06/2023	Update	Explanation of Benefits Example	General Billing Guidelines
03/06/2023	Delete	Availity EDI Clearinghouse	General Claim Submission Guidelines
06/21/2023	Update	HS PO Box updated from PO Box 16309, Lubbock, Texas 79490 to PO Box 240356, Apple Valley, MN 55124	Paper claim submission, Claims Appeal Guidelines, Provider Quick Reference Guide, Member ID card image
06/21/2023	Update	Multiple Shifts/Same Service Date	Personal Care Services – Dates of Service 1/1/2018 & Greater CDPAS/CDPAP – Dates of Service 1/1/2018 & Greater
06/21/2023	Update	New Section Supported Employment (SEMP)	Supported Employment (SEMP)
07/28/2023	Update	Added Billing codes 4755-4758	Community Habilitation Services
02/20/2024	Update	Diagnosis Qualifier	General Claims Submission Guidelines
4/10/2024	Add	Web-Based Claims Submission	General Claims Submission Guidelines
4/10/2024	Update	Updated links	Office Laboratory
8/30/2024	Update	Units	OPWDD Services
8/30/2024	Update	Units	General Claim Submission Guidelines
9/6/2024	Update	837 Electronic Claim Submissions	General Claim Submission Guidelines

2/2/2026	Update	Remove reference to CareVu	General Claim Submission Guidelines
2/2/2026	Update	Back of ID Card	Member ID Card
2/2/2026	Update	Remove Change HealthCare	General Claim Submission Guidelines
2/2/2026	Update	Calendar Year – Professional Claims	General Claim Submission Guidelines
2/2/2026	Update	Update link to rate code	OPWDD Services
2/2/2026	Update	Change nThrive to FinThrive	FinThrive
2/2/2026	Update	Update link to LCD & NCD	FinThrive
2/2/2026	Delete	Removed section on CareVu	CareVu
2/2/2026	Update	Updated link to FAQ & Provider Quick Reference Guide	Provider Quick Reference Guide
2/2/2026	Update	Clinical and Claim Payment Appeal information	Clinical and Claim Appeal Guidelines