Chapter IV
HEALTH CARE PROFESSIONAL PROVIDER MANUAL

This bulletin contains updates for Chapter IV - Health Care Professional Provider Manual. To get the entire up-to-date version of Chapter IV - Health Care Professional Provider Manual, go to the Uniform Billing Project section of this website:

www.mdch.state.mi.us/msa/mdch_msa/medicaid_data.htm

MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Issued: August 1, 2001

Subject: Uniform Billing Project, Chapter IV (Billing and Reimbursement) for Professional Services billed on the HCFA 1500 or ASC X12N 837 version 3051 or Michigan Medicaid interim version 4010 (not HIPAA compliant)

Effective: August 1, 2001

Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Program

The purpose of this bulletin is to transmit technical changes to Chapter IV, Healthcare Professionals Provider Manual, Billing and Reimbursement that will be effective for claims submitted by the above providers on or after August 1, 2001. The changes are clarifications, corrections, deletions and additions that are necessary as a result of publishing the policies associated with adopting the use of the HCFA 1500 paper claim form and related EDI formats.

The following changes are being made:

- In addition to accepting the ASC X12N 837 professional version 3051, the Department will also accept a Michigan Medicaid interim version 4010. This is not a HIPAA compliant version. Implementation guides and other important electronic billing information can be found on our website at www.mdch.state.mi.us/msa/mdch_msa/UniformBilling/index.htm. Providers may also e-mail AutomatedBilling@state.mi.us.
- Section 1, page 1: Reference to accepting the Michigan Medicaid interim 4010 has been included.
- Section 2, page 1: Reference to accepting the Michigan Medicaid interim 4010 has been included.
- Section 2, page 2: Instructions for providing separate paper attachments with electronic claims is deleted. The program will continue to require that claims with extraneous attachments be submitted on paper. Comments or additional information may be reported in the appropriate segments of the electronic record.
- Section 3, page 3: Item 9 is changed to read "If the patient has more than one insurance in addition to Medicaid, enter the primary insurance information in 11 through 11d and enter the name of the insured for the second commercial insurance here."
- Section 3, page 4: Item 14 is clarified to be an eight-digit date (MMDDCCYY).
- Section 3, page 9: Item 24J, COB indicator 8 is clarified to also identify that a patient's private carrier policy has been terminated or expired.
- Section 3, page 9: The Note identifying when an EOB must be attached to a paper claim is clarified to exclude COB 8. If a private insurance is terminated/expired or never covers a specific service, it is not necessary to bill the other insurer in order to submit an EOB. Box 19 (or the 2300 NTE segment) must include why the service is not covered (terminated, expired, excluded service).
- Section 6, page 2: Sterilization and hysterectomy consent forms should be faxed to the program before billing for the service, not before the service is rendered. This eliminates the need for a paper attachment and confirms that the form is completed properly.
- Section 6, page 3: Billing for immunizations is clarified. When billing for free vaccine obtained under the Vaccine for Children program, the charge must be reported as 000 (zero dollars) on the claim.
- Section 6, page 5: Information on billing surgical trays in the office setting is deleted consistent with the policy published in bulletin MSA 01-09 issued April 1, 2001.
- Section 7, page 2: Modifier 56 information is corrected to be consistent with policy published in bulletin MSA 01-09 issued April 1, 2001.
- Section 7, page 5: RT and LT modifier use clarified. Modifiers BP and BR deleted and modifier VG added consistent with policy published in bulletin MSA 01-08 issued April 1, 2001.

We have noticed some critical errors on paper HCFA 1500 test claims. Providers should pay attention to the following and ensure that claims are prepared correctly to avoid rejections and pends when HCFA 1500 claims are submitted August 1, 2001 and after.

- Field 33: The 9 digit Medicaid provider ID number must be reported here. The first 2 digits are your provider type code and the last 7 digits are your ID#. All 9 digits must be reported in this order with no dashes or slashes.
- Paper claims must not contain smudges, different fonts, handwritten items (other than the signature), staples, folds, etc. Original red ink forms must be submitted – no copied documents are allowed.
- Field 24I, emergency indicator is a **mandatory** field and must be completed with a Y if an emergency or N if not an emergency.
- All dates must be in an 8-digit format (MMDDCCYY) such as 08012001. Do not report six-digit dates.
- The place of service must be reported using 2-digit values as identified in Chapter IV. Single-digit place codes will not be valid for any claims submitted 8-1-01 or after.

Manual Maintenance

Attached to this bulletin are replacement pages for Chapter IV issued January 1, 2001 with Bulletin MSA 01-01. If you need a complete up-to-date Chapter IV, it can be downloaded from our website at www.mdch.state.mi.us/msa/mdch_msa/UniformBilling/index.htm.

When the HCFA 1500 claim form and related electronic formats are implemented for all Medicaid providers who will use it, a complete updated Chapter IV will be made available. This is scheduled for February 2002.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@state.mi.us. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved:

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INTRODUCTION

This chapter contains the information needed to submit professional claims to the Michigan Department of Community Health (DCH) for Medicaid, Children's Special Health Care Services (CSHCS), and the State Medical Program (SMP). It also contains information about how we process claims and how we notify you of our actions.

The following types of providers must use the National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051 or Michigan Medicaid interim 4010) when submitting electronic claims and the HCFA 1500 claim form for paper claims:

Ambulance Providers
Certified Nurse Midwives
Certified Nurse Practitioners
Certified Registered Nurse Anesthetists
Chiropractors
Clinical Lab Providers
Community Mental Health Service Providers
Family Planning Clinic providers
Maternal and Infant Support Service Providers
Medical Clinics
Optical Companies
Optometrists
Oral Surgeons
Physical Therapists
Physicians, MD & DO
Podiatrists
School Based Service Providers

CLAIMS PROCESSING SYSTEM

All claims submitted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically. We encourage claims to be sent electronically by file transfer or through the data exchange gateway. Electronic filing is more cost effective, more accurate, and payment is received quicker.

The CP System consists of several cycles:

The daily cycle is the first set of computer programs to process all claims (paper and electronic). The daily cycle is run five to six times each week and performs a variety of editing (e.g., provider and beneficiary eligibility, procedure validity). All claims are reported out as pended, rejected, or tentatively approved.

The weekly cycle is run once each week using the approved claims from the daily cycles that were run during the previous seven days. The weekly cycle edits claims against other paid claims and against certain reference files. Weekly editing includes duplicate claims, procedures with frequency limitations, etc. The provider's check (warrant) and remittance advice (RA) are also generated from this cycle. All claims are reported out as pended, rejected, or approved for payment.

REMITTANCE ADVICE

Once claims have been submitted and processed through the CP System, a remittance advice (RA) will be sent to the provider and to the billing agent if applicable. See the RA section of this chapter for additional information about the RA.

ADDITIONAL RESOURCE MATERIAL

Additional information needed to bill may include:

Provider manuals: These manuals include program policy and special billing information. Provider manuals and other program publications are available at a nominal cost from DCH. See Section 10 for information on ordering manuals and publications.

Bulletins: These intermittent publications supplement the provider manual. The bulletins are automatically mailed to subscribers of the affected provider manuals. Recent bulletins can be found on the DCH website.

Numbered Letters: General program information or announcements are transmitted to providers via numbered letter. These can be found on the DCH website.

Remittance Advice Messages: RA messages are sent to specific provider groups with the remittance advices and give you information about policy and payment issues that affect the way you bill and receive payment.

Medicaid Procedure Code Manuals: These list procedure codes, coverage and documentation requirements and are available on the DCH website.

Note: Find the DCH website at www.mdch.state.mi.us. Click on *Medical Services Administration* and proceed to *Provider Information.*

CPT and HCPCS Codes: You must purchase these two publications listing national CPT and HCPCS codes annually. The publications are available from many sources, such as the AMA Press at 1-800-621-8335 or Medicode at 1-800-999-4600.

International Classification of Diseases (ICD-9-CM): Diagnosis codes are required on your claims using the conventions detailed in this publication. This publication should be purchased annually. It may be requested from Medicode at 1-800-999-4600, or the AMA Press at 1-800-621-8335.

HOW TO FILE CLAIMS

You may submit your claims **electronically** or on **paper.** Electronic claim submission is the method preferred by DCH.

Electronic Claims

Claims submitted electronically are entered directly into the Claims Processing System resulting in faster payments, and fewer pends and rejects. Claims can be submitted by file transfer or through the data exchange gateway. The electronic format is the National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051 or Michigan Medicaid interim version 4010).

For information on submission of electronic claims, the ASC X12N 837 professional User's Guide, and envelope information, go to the DCH website at: http://www.mdch.state.mi.us/msa/mdch_msa/UniformBilling/index.htm.

Authorized Billing Agents

Any biller who submits claims electronically directly to the DCH must be an authorized electronic billing agent. The electronic billing specifications can be found on our website and contain specific information about electronic billing and the electronic record set for professional claims. You must complete our test process that consists of creating a test file of a minimum 25 new claims and achieving a successful test run of that data through our Claims Processing System. Additional claims may be required if the testing shows a problem area. The test claims will not be processed for payment. Any real claims for services rendered must be billed on paper until you have been approved to bill electronically.

Once you have passed the systems test, you will be issued a written authorization to participate as an electronic billing agent. Once you are an authorized electronic billing agent, any provider (including yourself) who wants you to submit claims on their behalf must complete and submit the Billing Agent Authorization (MSA-1343) form to the DCH. This certifies that all the services the provider renders are in compliance with Medicaid's guidelines. We will notify each provider when it has been processed. At that time, you can begin billing electronically for yourself or other providers that have been approved to use you as their billing agent. If claims are submitted prior to receiving DCH authorization, they will be rejected.

Any individual provider can submit claims electronically as long as our authorization process is met, however, many providers find it easier to use an existing authorized Billing Agent to submit claims to the program. Most billing agents will accept claims electronically, in diskette, or on paper. The billing agent takes claim information gathered from all of its clients and formats it to DCH standards. The data are then sent to the DCH for processing. Whether you submit claims directly or through another authorized billing agent, you will receive a remittance advice (RA), which reflects your individual claims. Your billing agent will receive an RA that will contain information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents:

E-mail: AutomatedBilling@state.mi.us

Or write to:

Michigan Department of Community Health
Medicaid EDI Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

HCFA 1500 Claim Completion Instructions

1. Insurance: Show the type of health insurance coverage applicable to this claim by checking the appropriate box.

1a. Insured's I.D. Number: Enter the patient's eight digit Medicaid identification number.

2. Patient's Name: Enter the patient's last name, first name, and middle initial, if any.

3. Patient's Birth Date AND Sex: Enter the patient's 8-digit birth date (MMDDCCYY) and sex.

4. Insured's Name: If there is private or group health insurance covering the beneficiary, list the name of the insured (policy holder) here. When the insured and the patient are the same, enter the word SAME. If there is no other insurance, leave blank.

5. Patient's Address: Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

6. Patient Relationship to Insured: Check the appropriate box for patient's relationship to insured when item 4 is completed.

7. Insured's Address: Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 and 11 are completed.

8. Patient Status: Check the appropriate box for the patient's marital status and whether employed or a student.

9 Other Insured's Name: If the patient has more than one insurance in addition to Medicaid, enter the primary insurance information in 11 through 11d and enter the name of the insured for the second commercial insurance here.

9a. Other Insured's Policy or Group Number: Enter the second insurance policy or group number.

9b. Other Insured's Date of Birth and Sex: Enter the insured's 8 digit date of birth (MMDDCCYY) and check the appropriate box for sex.

9c. Employer's Name or School Name: Enter the employer name or school name if applicable.

9d. Insurance Plan Name or Program Name: Enter the plan or program name of the second insurance.

10a. Is Patient's Condition Related to? Employment: Check YES or NO as appropriate.

10b. Is Patient's Condition Related to? Auto Accident: Check YES or NO. If YES, the two digit state code must be entered and the date of the accident must be reported in item 14.

10c. Is Patient's Condition Related to? Other Accident: Check YES or NO. If YES, the date of the accident must be reported in item 14.

10d. Reserved for Local Use: Leave blank. Not used by Medicaid.

11. Insured's Policy Group or FECA Number: This item MUST be completed if there is other insurance including Medicare. Enter the insured's policy or group number or HIC (Medicare Health Insurance Claim) number and proceed to items 11a. – 11c.

11a. Insured's Date of Birth: Enter the insured's eight digit date of birth (MMDDCCYY) and sex if different from item 3.

11b. Employer's Name or School Name: Enter the employer's name or school name if applicable.

11c. Insurance Plan Name or Program Name: Enter the complete insurance plan or program name.

11d. Is There Another Health Benefit Plan? If there is a second health benefit plan, mark the YES box and complete fields 9 through 9d. If no other plan, mark NO.

12. Patient's or Authorized Person's signature: Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to DCH necessary to process the claim.

13. Insured's or Authorized Person's signature: Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to DCH necessary to process the claim.

14. Date of Current Illness, Injury or Pregnancy: Enter the date of current illness, injury, or pregnancy as appropriate. If YES in item 10b or 10c the date of accident is required. Report the date as eight digits (MMDDCCYY).

15. If Patient has had a same or similar illness, give first date: Leave blank. Not required by Medicaid.

16. Dates Patient Unable to Work in Current Occupation: Leave blank. Not required by Medicaid.

17. Name of Referring Physician or other Source: Enter the referring/ordering provider's first and last name, and professional designation (e.g., MD, DO). All covered services which are the result of a physician's order or referral must include the referring/ordering physician's name.

17a. I.D. Number of Referring Physician: Enter the nine-digit Medicaid ID Number of the referring/ordering provider. The first two digits must be the Medicaid provider type code and the last seven digits must be the Medicaid provider ID number.

Refer to the Policy manual for situations where this number may be required. The referring/ordering provider ID number is always required when billing the following services:

Laboratory Services
Consultation Services
Nonemergency Ambulance Services

Ask for the ID Number when the referral is made. If the referring/ordering provider is not enrolled in Medicaid, enter nine 8's (888888888). The provider's name and professional designation must be reported in field #17.

24I. EMG – Emergency: Enter the appropriate emergency code:

Y = emergency

N = not an emergency

24J. Coordination of Benefits (COB): Enter the appropriate code from the list below. Note: do not bill Medicare covered and excluded services on the same claim. If none of the following conditions apply, leave this item blank.

1 = An insurance carrier other than Medicare made payment. Enter the payment in item 24K.

2 = Commercial HMO fixed co-pay only. Item 24F should be the fixed co-pay amount only.

3 = An insurance carrier other than Medicare applied the charges to the deductible.

4 = Both Medicare and another carrier made payment. Enter the total payment in 24K.

5 = Medicare only made payment. Enter the payment in 24K.

6 = Medicare risk HMO co-pay only. Item 24F should be the fixed co-pay amount only.

7 = Medicare applied all charges to the deductible.

8 = The patient has other insurance (other than Medicare) and this service is not covered OR the patient's other insurance is terminated or expired. Indicate the reason for nonpayment in Box 19 (2300 NTE segment for electronic claims.)

9 = Spend-down liability. Enter the spend-down liability of the patient in item 24K.

Note: The Medicare EOB and/or the other insurance EOB must be submitted with the claim if you entered 1, 3, 4, 5, or 7. The appropriate segments must be completed for electronic claims and no EOB is required.

24K. Reserved for Local Use: For Medicaid, report the sum of Medicare payment, and any other insurance payment or spend-down liability. Spend-down liability is the amount that the patient owes on the service. Do not use decimals, commas, or dollar signs.

25. Federal Tax I.D. Number (check box/SSN or EIN): Enter your provider of service or supplier Federal Tax I.D. number (Employer Identification Number) or your Social Security Number. Check the box of the number reported.
Note: The EIN or SSN reported here must correspond with the billing provider ID# in item 33.

26. Patients Account Number: Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is to assist you in patient identification. As a service, account numbers reported here will be reported back to you in the remittance advice.

27. Accept Assignment (check box): Leave blank. Not required for Medicaid.

28. Total Charge: Enter total of charges from item 24F lines 1-6.

29. Amount Paid: Enter the total amount of all payments/spend-down liability reported in item 24K. If you did not indicate the other insurance amount on each service line, enter the lump sum amount in item 29 and attach the EOB to the claim. If there was no other payment, leave blank.

30. Balance Due: Enter the balance due (from Medicaid) by subtracting Amount Paid (item 29) from Total Charge (item 28).

31. Signature of Physician or Supplier including degrees or credentials: A signature is required. See Chapter I for the provider certification requirements and acceptable signatures for the claim form.

32. Name and Address of Facility Where Services Were Rendered (if other than home or office): Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or the physician's office. When the name and address of the facility where the services were furnished is the same as the name and address shown in item 33, enter the word "SAME."

33. Physician's, Supplier's Billing Name, Address, Zip code and Phone #, PIN# and Group #: Enter the provider of service/supplier's billing name, address, zip code and telephone number.

Enter the provider's Medicaid nine-digit provider identification number on the bottom left side of the box next to "PIN#". Leave the space right of "GRP#" blank. The first two digits are the provider type code and the last seven digits are the assigned provider ID number for the location where the service was provided.

Note: The provider ID number reported here must correspond with the EIN or SSN reported in item 25.

For professional claims, many of the coding conventions described in CPT apply when submitting claims to the DCH. Additionally, HCFA guidelines apply in many instances. Some services may require additional billing information in order to receive correct reimbursement from Medicaid, CSHCS, and SMP. The following are provided to assist providers in reporting information correctly.

Do not send documentation with your claim unless you are asked to do so. The use of modifiers replaces documentation requirements in many instances.

If you have unusual circumstances to report, contact our Provider Inquiry staff for help at 1-800-292-2550 or email ProviderSupport@state.mi.us.

EVALUATION AND MANAGEMENT SERVICES

CPT E&M service guidelines apply for determining what level of care is appropriate. Generally CPT descriptions for E&M services indicate "per day" and only one E&M service may be reported per date of service.

Do not report a preventive medicine visit and an E&M visit for medical reasons on the same date unless the patient was seen at two separate times. If a patient is seen in the office at two different times of the day, for different levels of care, report on two service lines and indicate the time of each visit in item 19. If the same level of care visit is provided twice on the same day, report on one service line and use modifier 22. Indicate the time of day for each visit in item 19.

A procedure and a new patient E&M service on the same date should be reported using modifier 25 on the E&M service line.

Consultations require the referring/ordering provider's name and Medicaid ID # in item 17 and 17a.

To report emergency services in the office, report the applicable procedure (e.g., laceration repair) or the E&M office visit that represents the level of care provided.

Services such as telephone calls, missed appointments, interpretations of lab results cannot be billed as separate services.

SURGERY

CPT surgery guidelines for add-on codes, separate procedures, starred procedures, and bilateral services generally apply.

HCFA's global surgery guidelines apply. Use the appropriate modifiers to identify what service was provided.

When reporting post operative care only for surgical procedures with 10 or 90 day global periods, the provider assuming the care must bill the date of the surgery and the appropriate surgical code. The claim cannot be submitted until after the patient is seen. Report the date care was assumed/relinquished in item 19.

For multiple surgical procedures performed during the same surgical session, report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier 51.

If two identical surgical or procedural services are provided on the same day to the same patient, and cannot be reported as a bilateral procedure, bill on two service lines with no modifier on the first line and modifier 51 on the second line. Multiple surgery rules apply. If more than two identical services are provided on the same day, the second and subsequent identical services must be combined on the second line. Report modifiers 51 and 22 and provide an explanation of the circumstances.

If a bilateral procedure is performed, report the bilateral code if available. When there is no code describing bilateral services, report the service on one line and use modifier 50.

Sterilization and hysterectomy consent forms may be faxed to the program for acknowledgement of proper completion before the service is billed to the program. The fax number is 1-517-241-7856. If completed properly, there is no need to submit a copy of the form with the claim. Indicate “consent on file” in item 19.

ANESTHESIA SERVICES

Report anesthesia services with the 5 digit CPT anesthesia codes. Only one anesthesia service should be reported for a surgical session. Use the code of the major surgery.

Every anesthesia service must have an appropriate anesthesia modifier reported on the service line.

Report one time unit in item 24G for each minute of anesthesia time. Do not include base units.

If allowable surgical services are reported in addition to the anesthesia procedure, do not report time units for surgical services.

Do not report CPT Physical Status Modifiers or Qualifying Circumstance procedure codes to Medicaid.

RADIOLOGY SERVICES

If bilateral x-rays are performed on extremities, report on two service lines with modifier RT on one and modifier LT on the other.

If the same x-ray is performed multiple times on the same patient on the same day, (e.g., before and after fracture care) report the appropriate quantity in item 24G.

For radiology services with global, professional and technical components, practitioners can bill the global service in the non-hospital setting or professional component service in any setting. Practitioners cannot bill the technical component only.

LABORATORY SERVICES

CPT definitions for panels apply. All services in the panel must be provided and each test must be appropriate to the diagnosis or symptom for which the test was ordered.

All clinical lab services billed to the program must have a referring/ordering Medicaid provider name and ID# in item 17 and 17a.

All clinical lab services billed to the program must have a CLIA number in item 23.

If it is medically necessary to repeat the same clinical lab test on the same day for the same patient, report the first test on one line with no modifier and the second on the next line with modifier 91.

ANCILLARY MEDICINE SERVICES

If an injectable drug is given on the same day as an another service, the administration is generally part of the other service and cannot be reported separately. Only the procedure code for the cost of the drug should be reported.

Immunizations must be reported using the administration fee code(s) and the code identifying the type of vaccine given. Each vaccine/toxoid given must be reported in addition to the appropriate CPT administration code(s). The immunization administration is covered in addition to the vaccine even if an E/M visit is reported on the same day. Immunizations included in the Vaccine For Children (VFC) program are free so the charge for the vaccine must be reported as 000 (zero dollars).

For allergy immunotherapy services, only component services are billed. Report the number of doses of allergy extract or stinging insect venom prepared and billed at one time.

For diagnostic tests with global, professional and technical components, practitioners can bill the global service in the ambulatory setting or professional only component service in any setting. Practitioners cannot bill the technical component only.

MATERNITY CARE SERVICES

CPT guidelines for reporting prenatal care and delivery services apply. Bill the global service as appropriate if the same physician or a single group practice provides prenatal care, delivery and postpartum care.

The individual prenatal care or delivery codes should only be billed when different physicians (not in the same group) provide the services.

The number of prenatal visits may vary depending on when the patient first seeks care. Typically a patient will have about 13 visits. For a high risk pregnancy, report the appropriate E&M service in addition to the maternity care service. The diagnosis must be for the high risk condition.

Postpartum care can be billed as a separate service only when provided by a physician or group practice that did not perform the delivery services.

For twin gestation, report the service on two lines with no modifier on the first and modifier 51 on the second. This applies to the global, prenatal or delivery services. If multiple gestation for more than twins is encountered, report the first service on one line and combine all subsequent births on the second line with modifier 51 and 22. Provide information in item 19 or submit an attachment to the claim explaining the circumstances.

AMBULANCE

All nonemergency ambulance services billed to the program must have the referring/ordering physician's name and ID # in item 17 and 17a.

When billing for ambulance services, providers must include the appropriate origin and destination modifier on any service line billing for mileage. The first character of the modifier is the origin code and the second character of the modifier is the destination code. (e.g. Use modifier RM for a transport from the residence to the emergency room.)

Origin and Destination Modifiers

D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Non-hospital-based dialysis facility
M	Hospital emergency room
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

No additional payment is made for the first 30 minutes of waiting time, i.e., the code may not be billed to the program. If more than 30 minutes of waiting time occurs, report the code and enter the appropriate number of time units in item 24g billing one time unit for each 30

minutes of waiting time over and above the first 30. Documentation regarding the circumstances must be submitted with the claim.

When billing a mileage code, enter the number of whole miles the beneficiary was transported in item 24g. Do not use decimals.

VISION

A routine eye exam must be reported by physicians and optometrists with one of the following procedure codes:

S0620 - routine ophthalmological examination including refraction; new patient or
S0621 - routine ophthalmological examination including refraction; established patient

A routine eye exam includes history, visual acuity determination, external exam of the eye, binocular measure, ophthalmoscopy with or without tonometry, with plotting of visual fields, with or without biomicroscopy (slit lamp) and with or without refraction. A refraction cannot be billed separately.

E&M vision codes from CPT should only be billed with a medical diagnosis.

Report the date eyeglasses are dispensed as the date of service in item 24A. If eligibility or enrollment status changes after eyeglasses are ordered but before they are delivered, the order date of the glasses must be reported as the date of service in item 24A.

MISCELLANEOUS

All unlisted codes require documentation of the services provided in order to be considered for payment.

Use ICD-9-CM coding conventions to report the diagnosis code(s) at the highest level of specificity. E codes cannot be reported as a primary diagnosis. If an E code is reported as primary, or if a code requiring a fourth or fifth digit is not reported, the claim cannot be paid.

For elective services requiring prior authorization, authorization must be obtained before the service. A letter confirming coverage or denial of the service will be sent back to you along with a 9 digit PA number. **Do not submit the letter to the program when billing. Report the PA number in item 23.**

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Procedure codes may be modified under certain circumstances to more accurately represent the service or item rendered. There are three levels of modifiers, Level I being those included in CPT and updated annually by the American Medical Association, Level II recognized nationally and updated annually by HCFA, and Level III, those assigned for use within an individual state. All three levels are two digits.

Definitions and use of Level I modifiers can be found in the annual edition of the CPT. Definitions of Level II modifiers are found in the annual edition of HCPCS National codes. Definitions of Level III modifiers can be found in publications from the DCH. Providers should refer to their policy manual for more information on the use of these modifiers.

The modifiers listed below must be reported when applicable and affect the processing and/or reimbursement of claims billed to the DCH for Medicaid, CSHCS, and SMP beneficiaries. Other modifiers in Level I and II may be used to provide additional information about the service but won't be considered in the processing of your claim.

Component Billing

Certain procedures are a combination of a professional component and a technical component and must be reported in order to receive reimbursement.

26	Professional Component	Must be reported when billing only the professional component of a procedure. Providers are limited to billing the professional component for certain services in a facility setting.
TC	Technical Component	Reserved for facility billing. Practitioners should not report.

Evaluation and Management Services

21	Prolonged Evaluation and Management Services	Use to report a service that is greater than that usually required for the highest level of an evaluation and management service. A report or remarks explaining the service is required.
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	E&M services unrelated to the surgery and billed by the surgeon during the postoperative period of a global surgery are not payable without this modifier.
25	Significant, Separately Identifiable Evaluation and Management Services by Same Physician on Same Day of the Procedure	E&M services reported without modifier 25 and billed in addition to other procedures/services on the same day are not payable. Allows significant separately identifiable E&M services to be paid without review. Subject to postpayment audit.
57	Decision for Surgery	Required for an E & M service provided the day of or the day before a procedure with a 90 day global period to indicate that the service was for the decision to perform the procedure.

Surgical Services

50	Bilateral Procedure	Report to identify that bilateral procedures were performed during the same operative session. Reimbursement is 150% of the fee for the procedure or the provider's charge if bilateral reporting is appropriate.
51	Multiple Procedure	Use to report multiple procedures during the same operative session. Report on each additional procedure, not on the primary procedure. Determines payment at 100%, 50%, 50%, etc. when appropriate.
52	Reduced Services	Report if a service or procedure is partially reduced or eliminated at the physician's discretion. A report or remarks are required to determine reimbursement.
53	Discontinued Procedure	Report if a surgical or diagnostic procedure is terminated after it was started. A report or remarks are required to determine reimbursement.
54	Surgical Care Only	Reported by the surgeon for surgical procedures with 10 or 90 day global periods when all or part of the post op care is relinquished to a physician who is not a member of the same group. Reimbursement will reduced to the surgical care rate only.
55	Postoperative Management Only	Reported by the physician furnishing postop management only. Report the surgical procedure with the date of surgery and the date care was relinquished/assumed in Box 19.
56	Preoperative Management Only	Do not report. Preoperative management is part of the surgical care and is not covered separately. Claims billed with modifier 56 will be rejected.
58	Staged Or Related Procedure Or Service By The Same Physician During The Postoperative Period.	Allows payment for subsequent surgical procedures performed during the global surgery period that meet certain requirements. Do not use in place of modifier 78.
59	Distinct Procedural Service	Report/remarks required. Do not report if another modifier is more appropriate.
60	Altered surgical field	Report/remarks required.
62	Two Surgeons	Determines reimbursement when two surgeons were involved in the same surgery.
66	Surgical Team	Determines reimbursement for complex surgery requiring a surgical team. A report or remarks are required.
76	Repeat procedure by same physician	Report when a procedure or service is repeated by the same physician subsequent to the original service.
78	Return to the Operating Room for a Related Procedure During the Postoperative Period:	When appropriate, allows payment for related services (complications) requiring a return to OR during the postoperative period. Payment is reduced to operative care only.
79	Unrelated Procedure or Service by Same Physician During Postoperative Period	When appropriate allows payment for services during the postoperative period unrelated to the original surgery.

LT	Left side (used to identify procedures performed on the left side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.
Q5	Service furnished by substitute physician under a reciprocal billing arrangement	The name of the physician providing the service must be reported in item 19.
Q6	Service furnished by a locum tenens physician	The name of the physician providing the service must be reported in item 19.
RT	Right side (used to identify procedures performed on the right side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.

Vision

VG	Industrial thickness polycarbonate lenses	Determines payment rate to contractor.
VH	High index lenses	Determines payment rate to contractor.
VI	Industrial thickness lenses	Determines payment rate to contractor.
VC	Polycarbonate lenses	Determines payment rate to contractor.
VP	Aphakic patient	Report to identify that service is for aphakic patient.
55	Postoperative management only	Reported by an optometrist (with TPA certification) for select services when a physician performs the surgical procedure and relinquishes the follow-up care to the optometrist.

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