PROVIDER CLAIMS MANUAL

Revised June 27, 2021

300 South Riverside Plaza, Suite 500
Chicago, IL 60606
312-705-2900
866-606-3700

Dear MeridianHealth Provider,

MeridianHealth would like to welcome you to the Meridian network of providers! Our Provider Claims Manual was designed to assist you with understanding policies, procedures, and other protocols relating to Illinois Medicaid, as well as to be used a reference tool for you and your staff.

The Provider Claims Manual is a dynamic tool and will evolve with MeridianHealth. Minor updates and revisions will be communicated to you via *Provider Updates*, which serve to replace the information found within this Provider Claims Manual. Major updates and revisions will be communicated to you via a revised edition of the Provider Manual, which will be provided to you. The revised edition will replace older versions of the Provider Manual.

The latest Provider Manual is always available on our website at **ilmeridian.com/providers/resources/forms-resources.html.**

Please contact your local Provider Network Development Representative or our Provider Services department at 866-606-3700 with any questions or concerns. If you are not yet a contracted provider with Meridian, visit our website at **ilmeridian.com/providers.html**.

Thank you for your participation.

MeridianHealth

Table of Contents

Section 1: Billing and Claims Payment

Overview
The focus of Meridian's Claims department is to precisely process claims in a timely manner. Meridian has established toll-free telephone numbers for providers to access a representative in Meridian's Claims Department.

IL Provider Number: 866-606-3700

Claims Billing Requirement
Sample forms for the CMS 1500 and the UB-04 forms are provided at the back of the manual[1].
In order to receive reimbursement in a timely manner, please ensure all providers are registered with the State of Illinois and have an Illinois Healthcare and Family Services (HFS) Medicaid Provider ID number. Also, ensure that each claim:

- Uses the data elements of UB-04 (UB-04 Version 050) or CMS 1500 as appropriate
  - CMS 1500 Claim Form Sample: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf
  - http://www.dhs.state.il.us/page.aspx?item=31593
    - Attachment B: CMS 1500 Form Example
    - Attachment C: UB-92 Claim Form Example
- Is submitted within 180 days of service for Medicare or Medicaid primary claims
- Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service and includes a matching provider ID number assigned by the Plan
- Identifies the patient (Member ID number assigned by Meridian, address, and date of birth)
- Identifies the plan (plan name and/or Member ID number)
- Lists the date (*mm/dd/yyyy*) and place of service
- If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Meridian
- Includes additional documentation based upon services rendered as reasonably required by Meridian Medical Policies.
- Is certified by provider that claim:
  - Is true, accurate, prepared with knowledge and consent of provider,
  - Does not contain untrue, misleading, or deceptive information

[1] See *Appendix I* for example forms

    - Identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim

- Is a claim for which the provider has verified the member's eligibility and enrollment in Meridian before the claim was submitted

- Is not a duplicate of a claim submitted within 45 days of the previous submission

- Is submitted in compliance with all of Meridian's prior authorization and claims submission guidelines and procedures

- Is a claim for which provider has exhausted all known other insurance resources

- Is submitted electronically if the provider has the ability to submit claims electronically

- Is submitted with appropriate NPI, taxonomy, and provider category of service for services rendered on the submitted claim. Information on appropriate taxonomy and category of service can be found at the following link:

    - https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

Taxonomy Codes

Taxonomy Codes are designed to categorize the type, classification, and/or specialization of healthcare providers. To ensure accurate and timely claims processing and payment effective 1/01/17 Meridian will require all claims, both paper and electronic, to include the taxonomy code of the rendering provider. The taxonomy code included on the claim must also match the taxonomy code Meridian has on file for the rendering provider. To submit or update this information please complete the provider enrollment form located on our website.

Provider Appeal and Claim Dispute Process

Definitions:

- ***Provider Appeals*** – provider appeals are administrative or pre/post service related to services that are denied
- ***Provider Claim Disputes*** – provider claim disputes are related to claim payment denials, processing and/or payment discrepancies

Meridian's provider appeal and claim dispute process is available to all providers, regardless of whether they are in- or out-of-network.

What Types of Issues Can Providers Appeal?

The chart below outlines the differences between a provider appeal (administrative, pre-service and post-service) and a provider claim dispute and how to file each one respectively.

Please note that the provider appeal process is in place for two main types of issues:

1. The provider disagrees with a determination made by Meridian. In this case, the provider should send additional information (such as medical records) that support the provider's position.
2. The provider is requesting an exception to a Meridian policy, such as prior authorization requirements. In this case, the provider must explain the circumstances and why the provider feels an exception is warranted in that specific case.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to a member being ineligible on the date of service or non-covered benefits.

How to File an Appeal

The chart below outlines the differences between a provider appeal (administrative, pre-service and post-service) and a provider claim dispute and how to file each one respectively.

Appeal Type	Where to Submit
Administrative Appeals Appeal of a claim denied for failure to authorize services according to timeframe requirements. This includes: • Inpatient Admission/Skilled Nursing Facility • Surgery • Physical/Occupational/Speech Therapy • Hospice	**MeridianHealth** ATTN: Appeals Department PO Box 4020 Farmington, MO 63640-4402
Pre-Service Appeal Providers may file an appeal of a denial prior to rendering the service (pre-service) or during an ongoing course of treatment (concurrent) if they are appealing on behalf of the member. For expedited/urgent* pre-service appeals, the treating provider will be automatically deemed the authorized representative for the member. For all other appeals, a signed authorized representative form **must** be obtained from the member.	**MeridianHealth** ATTN: Appeals Department PO Box 44287 Detroit, MI 48244 Fax Number: 833-383-1503

**Expedited appeals* *mean you feel that a delay in treatment could seriously jeopardize the life or health of the member.* Examples of pre-service appeals include, but are not limited to: • Denied Elective Surgery • Denied Continued Stay at a Skilled Nursing Facility • Denied Prior Authorization for an Inpatient Admission	
Post-Service Provider Appeals Appeals of services that were denied or reduced and have a denied authorization request on file. This excludes administrative denials (denials for lack of authorization). Examples of services that can be appealed through the post-service provider appeal process: • Denied Days for an Inpatient Stay or Denied Level of Care for an Inpatient • Denied Air Ambulance Transport • Denied Hospice Stay • Combined 15-30 Day Readmission	**MeridianHealth** ATTN: Appeals Department PO Box 4020 Farmington, MO 63640-4402
Provider Claim Dispute **Disputes may be filed via the web Secure Provider Portal (Preferred) or via mail. If mailing please clearly identify the request as a dispute:** **Dispute Portal:** **For DOS prior to July 1, 2021:** Claims Dispute Form (mhplan.com) **For DOS on or after July 1, 2021:** **provider.ilmeridian.com** Disputes related to claims processing are handled separately from Administrative Appeals or Post-Service Provider Appeals. Claim disputes are disputes regarding the following: • Inaccurate Payment • Coding Edits (Correct Coding Initiative (CCI) edits) • Claims Denied as a Duplicate • Untimely Filing • Claims Denied for No Primary Payer EOB	**For DOS on or after July 1, 2021 use:** MeridianHealth Attn: Claims Appeals PO Box 4020 Farmington, MO 63640-4402

Timeframe for Filing a Post Service Appeal

Appeals must be filed within **90 days** from the remittance date. Appeals submitted after the timeframe has expired may not be reviewed.

Response to Post-Service Appeals

Meridian typically responds to a post-service claim appeal within 30 days from the date of receipt. If additional information is needed, such as medical records, then Meridian will respond within 30 days of receiving the necessary information. Providers will receive a letter with Meridian's decision and rationale.

There is only one level of appeal available within Meridian. All appeal determinations are final. If a provider disagrees with Meridian's determination regarding an appeal, the in- or out-of-network provider may pursue other options below depending on the health plan the member is enrolled with.

Medicaid-Specific Guidelines

Binding Arbitration – A provider may initiate arbitration by making a written demand for arbitration to Meridian. The Provider and Meridian agree to mutually select an arbitrator and the process for resolution.

If you have any questions about the Meridian Medicaid post-service claim appeal process, please call 866-606-3700 for more information.

Section 2: Provider Specifics

Federally Qualified Health Center (FQHC)/Freestanding Rural Health Clinic (RHC)/ Encounter Rate Clinic (ERC)

- FQHC, RHC, and ERC claims must bill with the group National Provider Identifier (NPI)
- FQHC, RHC, and ERC behavioral health (BH) claims must include a BH modifier
- FQHC, RHC, and ERC claims must be billed on a CMS 1500
- FQHC, RHC, and ERC encounter claims should be billed with T1015 CPT code along with services provided

Therapy Claims

- ALL therapy claims must be billed on a CMS 1500

Laboratory

- ALL laboratory charges should be submitted to Meridian on a CMS 1500

Prenatal

- All prenatal claims must be billed with last menstrual period date

Inpatient and Hospital Billing

- All providers are expected to submit claims with appropriate NPI, taxonomy, and provider category of service for services rendered on the submitted claim. Information on appropriate taxonomy and category of service can be found at the following link: https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

Outpatient Hospital Billing

- Refer to the MeridianHealth Billing Manual for detailed information.

Behavioral Health

The Behavioral Health department at Meridian coordinates behavioral health care for Meridian members accessing services from contracted offices and Community Mental Health and substance abuse treatment providers in Illinois.

Hand-Priced Durable Medical Equipement (DME)

Durable Medical Equipment (DME) pricing is generally paid based on the State's DME fee schedule published on its website. This policy sets forth the billing methodology necessary when no rate is included in the published guidance. This practice is commonly referred to as hand-pricing. In cases where no rate is established on the State's fee schedule, Meridian utilizes the following payment methodologies:

Any hand priced DME procedure codes will be paying out at 25% of the billed charges.

Listed below is an explanation of behavioral health services that require or do not require prior authorization:

Mental Health

Prior Authorization Required	• Inpatient Hospitalization • Partial Hospitalization
Notification	• Intensive Outpatient Program • Outpatient therapy (Continued Outpatient Treatment Notification Form) • CMHC Rehabilitation services • SASS Services
No Prior Authorization Required	• Psychiatric Evaluation and Medication Management • Crisis Intervention • Treatment Planning Development/Review/Modification • Psychological and Psychiatric Evaluation

Substance Abuse

Prior Authorization Required	• Inpatient Hospitalization • Detoxification • Substance Abuse Residential
Notification	• Intensive Outpatient Program • Outpatient therapy (Continued Outpatient Treatment Notification Form)
No Prior Authorization Required	• Medication administration

Section 3: Community Mental Health Center Billing Guidelines

This guide establishes the standardized claims submission processes to be utilized across the HFS' contracted Managed Care Plans for the reimbursement of services rendered by certified and enrolled CMHCs. It is designed to provide guidance and clarification to both Managed Care Plans and CMHC certified providers. The HFS encounter claims system will accept encounter claims from the Managed Care Plans in line with the standardized claims submission requirements outlined in this guide.

Services Overview

HFS contracted Managed Care Plans are required to provide coverage for mental health services covered under the HFS Medical Assistance Program, as detailed in the Service Definition and Reimbursement Guide (SDRG), or its successor Provider Handbook.

Definitions

The following common terms are used throughout this Billing Guide.

1. Clinician refers to the qualified individual within a CMHC site delivering a covered service.

2. MHP refers to an individual who meets the definition for a Mental Health Professional as described in 59 Ill. Administrative Code 132.25.

3. Provider refers to a uniquely certified CMHC site, operating under a distinct National Provider Identification (NPI) number.

4. QMHP refers to an individual who meets the definition for a Qualified Mental Health Professional as described in 59 Ill. Administrative Code 132.25.

5. Rolled Up is a term used to describe how a provider may bill for numerous incidents of the same service provision during a day, done by totaling the number of separate units of the service provided onto one service line on a claim for the purposes of billing. Please see the Billing Examples section for additional details.

6. RSA refers to an individual who meets the definition for a Rehabilitative Services Associate as described in 59 Ill. Administrative Code 132.25.

4. Same Service refers to a specific service delivered at a specific level of care and at a specific location, represented on a claim by a distinct procedure code, modifier, and place of service combination.

General Claims Submission Requirements

1. To be reimbursed for services provided to a recipient who receives a HFS Medical Assistance Program benefit and who is enrolled with a HFS contracted Managed Care Plan, CMHCs must be fully contracted and credentialed with that Managed Care Plan on the date of service.

2. CMHC services may only be rendered from a certified site. The NPI number providers use to bill Managed Care Plans must correspond to a certified CMHC site.

3. Providers rendering both substance abuse and mental health services from the same site shall not

utilize the same NPI number for billing substance abuse and mental health services. Mental health services must be billed under a separate NPI number from substance abuse services. Providers that do not obtain and report a unique NPI for each provider type may be subject to claims denial.

4. Providers with multiple certified sites must obtain a unique NPI number for each CMHC site. Providers that do not obtain and report a unique NPI for each provider site may be subject to claims denial.

5. It is the responsibility of the provider to ensure compliance with all of the service requirements of a recipient's payer, including service notifications or prior authorizations, prior to providing CMHC services. Providers should reference the appropriate Managed Care Plan's Provider Handbook and their Provider Agreements for information on service requirements. A crosswalk of the prior authorization requirements of each of the HFS contracted Managed Care Plans can be found on the HFS website. Providers that do not comply with the service requirements of a recipient's payer may be subject to claims denial.

- Providers are expected to submit claims with appropriate NPI, taxonomy, and provider category of service for services rendered on the submitted claim. Information on appropriate taxonomy and category of service can be found at the following link: https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

Rendering and Billing Provider

1. Billing Provider: Billing Provider represents the payee on an individual claim. The NPI corresponding to the payee ID where a provider wants remittance advice and payments sent should be reported in loop 2010AA on 837P submissions or Box 33 on a CMS 1500 form. If the billing NPI also corresponds to the rendering provider site, no rendering provider NPI is required on the claim.

2. Rendering Provider: Rendering Provider represents the specific CMHC site that delivered the services on the claim. For CMHCs, Rendering Provider is captured at the entity level, not the individual clinician level. The NPI for the Rendering Provider must be reported if the Billing Provider NPI corresponds only to a payee ID or to a different provider site location. The Rendering Provider is reported in loop 2310B on 837P submissions or Box 24J on a CMS 1500 form.

CMHC as the Payee

It is allowable for qualified practitioners (i.e., physicians, Psychiatric Advanced Practice Nurses) to deliver psychiatric services in a CMHC and list the CMHC as the Billing Provider (loop 2010AA on 837P submissions or Box 33 on a CMS 1500 form) on the claim. For these claims to adjudicate appropriately as a practitioner service rather than a CMHC service, the claim must list the NPI for the practitioner delivering services in the Rendering Provider field (loop 2310B on 837P submissions or Box 24J on a CMS 1500 form) and report an allowable procedure code from the appropriate practitioner fee schedule.

The Rendering Provider must comply with the MCO's policies, procedures, and service requirements corresponding to the practitioner's provider type, including being enrolled as an active provider with HFS and the Managed Care Plan on the date of service.

Duplicate Claiming

CMHCs may provide multiple units of the same service to the same recipient on the same day, provided that claims are submitted pursuant to the following policies. MCO claiming systems shall be set up to recognize each distinct procedure code, modifier, and place of service combination covered under the HFS Medical Assistance Programs as a unique service.

Billing Guidelines and Examples:

1. Providers may only be reimbursed once for delivering the same service to the same recipient on the same day. Multiple units of the same service provided to the same recipient on the same day by the same provider must be "rolled up" onto one service line on a single claim in order to avoid a rejection for a duplicate claim.

Example 1: An MHP-level staff at a CMHC provides a total of 2 units of Case Management – Mental Health in the office to a single recipient, but at separate times of the day (not back to back). The service (same code/modifier/place of service combination), the provider NPI, the recipient, the date of service, and place of service all remain the same. The provider correctly bills Case Management – Mental Health on one service line using the following coding summary:

Service Line	Procedure Code	Modifier (s)	Place of Service	Units
1	T1016	TF	11	2

Example 2: An MHP-level staff at a CMHC provides 2 units of Crisis Intervention in the office to a single recipient. Later that same day, the same recipient returns to the same CMHC and a different MHP-level staff provides 2 additional units of Crisis Intervention to the recipient. The provider bills Crisis Intervention on two service lines on a single claim using the following coding summary:

Service Line	Procedure Code	Modifier (s)	Place of Service	Units
1	H2011		11	2
2	H2011		11	2

This claim has not been billed appropriately. Service Line 1 will positively adjudicate, but Service Line 2 will be denied as a duplicate claim. For CMHC services, the provider is identified at the entity level, not the clinician level. Therefore, because the recipient, the service (procedure code/modifier/place of service combination), the provider NPI, and the date of service all remained the same, the provider should roll up the services and bill Crisis Intervention on one service line using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2011		11	4

Example 3: An MHP-level staff at a CMHC provides 3 units of Mental Health Assessment in the office to a single recipient. A QMHP-level staff at the same CMHC provides 1 additional unit of Mental Health Assessment, also in the office, to the same recipient on the same day. The provider correctly bills Mental Health Assessment on two separate service lines using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H0031	HN	11	3
2	H0031	HO	11	1

The provider correctly separated the services provided onto two distinct service lines using appropriate modifiers to account for the change in the clinician qualification level.

2. Providers delivering the same service to the same client, but from two different places of services, under a single CMHC's NPI, on the same day must submit the services on two different service lines, using the appropriate place of service codes to distinguish the two services from one another.

Example 4: An MHP-level staff at a CMHC provides 2 units of Crisis Intervention in the office to a single recipient. Later that same day, the same MHP-level staff provides 2 more units of Crisis Intervention to the same recipient, but this time at the recipient's home. The provider correctly bills Crisis Intervention on two separate service lines using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2011		11	2
2	H2011		12	2

The provider correctly separated the services provided onto two distinct service lines using appropriate Place of Service codes to account for the change in location.

Example 5: An RSA-level staff at a CMHC provides 2 units of Community Support Individual to a single recipient at the recipient's school. Later that same day, an RSA-level staff provides 3 more units of Community Support Individual to the same recipient, but this time at a local community center. The provider bills Community Support Individual on two separate service lines using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2015	HM	99	2
2	H2015	HM	99	3

This claim has not been billed appropriately. Service Line 1 will positively adjudicate, but Service Line 2 will be denied as a duplicate claim. Although the physical location from which services were delivered changed from a school setting to a community center, the place of service code did not change. Consistent with the SDRG, the only place of service codes available for CMHC services are: office (11), home (12), and other place of service (99). Because the recipient, the service (procedure code/modifier/place of service combination), the provider's NPI, and the date of service all remained the same, the provider should roll up the services and bill Community Support Individual on one service line using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2015	HM	99	5

Section 4: Long-Term Services and Supports (LTSS) Waiver Programs

Overview

The goal of the Meridian Long-Term Services and Supports (LTSS) Program is to help members improve their well-being, avoid re-admissions, return to and/or remain living in the residence of their choice (including their home and community) and increase the quality of their life. The personalized service members receive with Meridian through their Community Care Coordinator (CCC) is unmatched. Members always have access to a live person, and they can customize their plan of care with their CCC to tailor their community support and healthcare needs and improve their outcomes. We have a robust array of service and support options to fit each member's needs[4].

Freedom of Choice

As part of the LTSS Program with Meridian, members have the choice of nursing facility placement, supportive facility placement or home and community-based services. Members also have the right to choose not to receive services. Members may choose which provider/agency they want to provide their LTSS. The Illinois Department of Rehabilitative Services and the Illinois Department on Aging have a list of doctors who provide services in each member's service area. A list of covered providers is reviewed with each member by their CCC. Members also have the right to choose not to get services.

Provider Choice

Meridian ensures members have a choice. This means the freedom to choose their own providers for waiver services. Meridian's team of Care Coordinators will work with members to find the provider that best meets their needs. Members will need to choose a provider from Meridian's network of waiver service providers. Members can search for providers in our online Provider Directory at ilmeridian.com or by calling Member Services at 866-606-3700. If a member wants to see a provider that is out of their network, we will work with members and the provider on a solution.

Transfer to Other Provider/Agency

Members may ask to change from one provider to another. If a member wants to change, they should call their CCC to help arrange the transfer.

Temporary Change in Residence

If a member will be temporarily residing in another location in Illinois and wants to continue to receive services; they will need to contact their CCC. CCCs will assist by arranging service transfers to their temporary location.

Waiver Programs

Below is information on the different types of LTSS waiver programs covered by Meridian[5]. This includes adults dependent on a ventilator. The service descriptions are defined below:

Adult Day Health (also known as Adult Day Services)

This is a daytime, community-based program for adults not living in Supported Living Facilities. Adult Day Health offers many types of social, recreational, health, nutrition and related support services in a protective setting. One ride to and from the center each day and lunch are part of this service.

Behavioral Services
These services are behavioral therapies designed to help members with brain injuries manage their behavior and thinking functions and enhance their ability to live independently.

Day Habilitation (also known as Habilitation)
For members with brain injuries, this service gives training with independent living skills, such as help with gaining, keeping or improving self-help, socialization and adaptive skills. This service also helps the member to gain or keep his or her greatest functional level.

Emergency Home Response (also known as Personal Emergency Response System (PERS))
This electronic equipment gives members 24-hour access to help in an emergency. The equipment is linked to your phone line and calls the response center and/ or other forms of help once the help button is pressed.

Environmental Accessibility Adaptations
These are physical changes to a member's home. The changes must be needed to support the health, welfare and safety of the member and to let the member to function with greater independence in his or her home. Without the change, a member would need some type of institutionalized living, such as a nursing facility or assisted living. Adaptations that do not help the member's safety or independence are not part of this service, such as new carpeting, roof repair, central air, or home additions.

Homemaker Services
An in-home caregiver is hired through an agency. The caregiver helps with household chores such as meal preparation, shopping, light housekeeping and laundry. The caregiver can also help with hands-on personal care such as personal hygiene, bathing, grooming, and feeding. Homemaker services will require authorization and be limited to eight hours per day. Certain cases that are reviewed by our medical team may allow for more. S5130 is a 15-minute code and should not be billed in excess of 32 units per day unless approved.

Home Delivered Meals
Prepared food is brought to the member's home each day. The meals may include a heated lunch meal and a dinner meal (or both), which can be refrigerated and eaten later. This service is designed for a member who cannot make his or her own meals but is able to feed him/herself.

Home Health Aide
A home health aide is a person who works under the supervision of a medical professional, nurse or physical therapist, to help the member with basic health services such as help with medication, nursing care or physical, occupational and speech therapy.

Nursing
Nursing offers skilled nursing services to a member in his or her home for short-term acute healing needs. The goal of this service is to restore and keep a member's highest level of function and health. This service is supplied instead of a hospital stay or a nursing facility stay. A doctor's order is needed for this service.

Nursing – Intermittent
This service focuses on long-term needs rather than short-term acute healing needs, such as weekly insulin syringes or medication set up for members who cannot do this for themselves. These services are supplied instead of a hospital stay or a nursing facility stay. A doctor's order is needed for this service.

Nursing Facility Program
The Nursing Facility Program is also called a Nursing Home, Long-Term Care Facility, or Skilled Nursing Facility. It is a licensed facility that provides skilled nursing or long-term care services after the member has been in the hospital. These facilities offer medical and non-medical needs for residents who need assistance and support to care for themselves due to chronic illness or disability.

Personal Assistant
A Personal Assistant is an in-home caregiver hired and managed by the member. The member must be able to manage many parts of being an employer such as hiring the caregiver, managing the caregiver's time and timesheets and completing other employee paperwork. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping and laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming and feeding. Personal Assistants can include other independent direct caregivers such as registered nurses, licensed practical nurses and Home Health Aides.

Physical, Occupational and Speech Therapy (also known as Rehabilitation Services)
These services are designed to improve and/or restore a person's functioning and include physical therapy, occupational therapy and/or speech therapy (PT, OT, ST).

Prevocational Services
This service is for members with brain injuries and offers work experience and training designed to help develop skills to work in the general workforce. Services include teaching concepts such as compliance, attendance, task completion, problem-solving and safety. These services are for members whose plan of care notes that they will be able to work within one year.

Respite
This service gives relief for unpaid family or primary caregivers who are meeting all the needs of the member. The respite caregiver helps the member with all daily needs when the family or primary caregiver is absent. Respite can be given by a homemaker, personal assistant, nurse or in adult day health center.

Supported Employment
Supported employment involves activities needed to keep paid work by people getting waiver services, including supervision and training.

Supportive Living Program (also known as Supportive Living Service)
An assisted living facility is a housing choice that gives members many support services to meet their needs to help keep members as independent as possible. Examples of support services to meet those needs are: housekeeping, personal care, medication oversight, shopping and social programs. Supportive Living does not offer complex medical services or supports.

If you have any questions regarding Meridian's HCBS Program, or the LTSS Program in general, contact Member Services at 866-606-3700.

[1]MeridianHealth does not determine your eligibility into the Waiver or Nursing Home programs. Eligibility determination is under either the Department on Aging or the Department of Rehabilitative Services.

Resource Utilization Groups (RUGs)

Section 4432(a) of the Balanced Budget Act (BBA) of 1997 modified how facilities are paid for skilled nursing facility (SNF) services. For cost reporting periods beginning on or after July 1, 1998, you are paid a comprehensive per diem under a Prospective Payment System. This SNF PPS per diem represents Medicare's payment for all costs of furnishing covered Part A SNF services (routine, ancillary, and capital-related costs.

Billing Requirements

Room and board services must be submitted on the institutional claim form:

- 837i for electronic claims
- UB-04 for paper claims

Professional services must be submitted on the professional claim form:

- 837p for electronic claims
- CMS 1500 for paper claims
- Providers are expected to submit claims with appropriate NPI, taxonomy, and provider category of service for services rendered on the submitted claim. Information on appropriate taxonomy and category of service can be found at the following link: https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

Taxonomy Codes

Illinois Healthcare and Family Services (HFS) will be looking for long-term care (LTC) claims to use the following taxonomy codes:

- **310400000X** – Assisted Living Facility – used by Provider Type 028 (Supported Living Facility)
- **311500000X** – Dementia Special Care – used by Provider Type 028 (Supported Living Facility-Dementia Care Unit) or by Provider Type 038 (
- **314000000X** – Skilled Nursing Facility – used by Provider Type 033 and 034 (Nursing Facility and State Operated Long Term Care Facility)
- **313M00000X** – Nursing Facility/Intermediate Care Facility – used by Provider Type 033 and 034 (Nursing Facility and State Operated Long Term Care Facility)

LTSS Billing Requirements

- Nursing Home and SNF claims must be billed monthly on a CMS 1500
- LTSS claims must be billed on a CMS 1500 with authorization number, specific LTSS CPT codes, and group NPI
- Supported Living Facility (SLF) must be billed monthly on a UB-40 form with revenue code 0190 (PT, OT, and ST included)

LTSS Provider Billing Chart

Service	Code	Modifier	HFS Increment
Physical Therapy	G0151	UC	per hour
Occupational Therapy	G0152	UC	per hour
Speech Therapy	G0153	UC	per hour
Speech Therapy – Hospital	G0153	UC	per hour
Home Health – Intermittent Nursing RN, LPN (Agency Provider)	G0154		one visit up to two hours
Home Health – Intermittent Nursing RN, LPN (Agency Provider)	G0154	SC	one visit up to two hours
Home Health Aide – Individual	G0156		per hour
Home Health Aide – Individual – CNA	G0156	SC	per hour

Adult Day Service	S5100		per hour
Personal Assistant	S5125		per hour
Homemaker	S5130		15 minutes
Homemaker with Insurance	S5130		15 minutes
Personal Emergency Response – Install	S5160		per install
Personal Emergency Response – Monthly Charge	S5161		per month
Environmental Home Adaptations	S5165		per service
Home Delivered Meals	S5170		one unit = 2 meals
Nursing, Skilled – LPN Individual	T1000	TE	per hour
Nursing, Skilled RN Individual	T1000	TD	per hour
Nursing, Skilled – Multi-Customer	T1002	TT	per hour
Nursing, Skilled – LPN Agency	T1003	TE	per hour
Nursing, Skilled RN Agency	T1003	TD	per hour
Home Health Aide – Agency	T1004		per hour
Home Health Aide – Agency – CNA	T1004	SC	per hour
Respite – RN	T1005	TD	per hour
Respite – LPN	T1005	TE	per hour
Respite – CNA	T1005	SC	per hour
Respite – Homemaker	T1005	HM	per hour
Respite – Personal Assistant	T1005		per hour
Respite/Adult Day Health	T1005	HQ	per hour
Respite/Adult Day Service Transport	T1005	HB	encounter/trip
Adult Day Service Transportation	T2003		1 unit = one way trip
Prevocational Services	T2014		per diem
Supported Employment	T2019		per diem
Habilitation – Day	T2020		per diem
Specialized Medical Equipment	T2028	RR	per service
Supportive Living Facilities	T2033		Per diem
Supportive Living Facilities - Bed Hold	T2033	U1	per diem
Nursing Facilities	190		
Nursing Facilities - Vent	194		

Durable Medical Equipment (DME)

Meridian policy directs providers to bill the date of delivery for durable medical equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the Comments/Remarks box on the claim.

Section 5: Adjustments

Voiding and Replacement Claims

If you are replacing or voiding and replacing a UB-04 claim, use appropriate bill type of XX7 or XX8. If you are replacing or voiding and canceling a CMS 1500 claim, please complete box 22. For a replacement or corrected claim, enter resubmission code 7 in the left side of box 22 and enter the original claim number of the claim you are replacing in the right side of box 22. If you are voiding and canceling a claim, enter resubmission code 8 on the left side of box 22 and enter the original claim number of the paid claim you are voiding/canceling on the right side of box 22.

All claim completion instructions apply for a void/cancel claim except as noted below:

- Complete one service line and enter zero dollars (000) in all money fields. The entire payment made on the first claim will be debited. A new claim may then be submitted using the correct beneficiary ID

After the void/cancel claim is submitted, a new claim containing the correct provider NPI and/or beneficiary ID number may be submitted.

A replacement claim must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after Meridian made payment. When a replacement claim is received, Meridian deletes the entire original claim and replaces it with the information contained on the replacement claim. All money paid on the original claim is debited and a new payment is issued based solely on information reported on the replacement claim.

Replacement claims should be submitted to:

- Return an overpayment and provide an explanation of the reason for the overpayment in Remarks section
- Correct information submitted on the original claim (other than to correct a provider NPI and/or beneficiary ID number) and provide an explanation of what information is being corrected
- Report payment from another source after Meridian paid the claim. Report the source of the payment (e.g. Medicare) in the Remarks section
- Correct information that the scanner misread (except a provider NPI or beneficiary ID number) and state reason in the Remarks section

Use CMS approved two-digit place of service codes to report location for provision of covered services.

Authorization

Effective 8/1/2015, prior authorization is required for all out-of-network providers and all outpatient procedures performed at both in- and out-of-network facilities before services may be performed for Medicaid members.

Please refer to your Authorization Overview for all services that require authorization for in-network providers.

Utilization Management Authorizations

For services that require prior authorizations to be approved for coverage, the Utilization Management department makes a coverage determination. All claims billed using the approved prior authorization

should have the authorization number noted in the appropriate location of the form. Refer to the claim form instructions as necessary.

Claims Billing Requirements

When billing for services rendered to Meridian members, providers must use the most current Medicaid-approved coding format (ICD-10, CPT, HCPCS, etc.) and/or state Medicaid guidelines for claims payment.

Please follow these guidelines for claims submission to Meridian:

- Providers must use a standard CMS 1500 Claim Form or UB-04 Claim Form for submission of claims to MeridianHealth
- Providers must use industry standard procedure and diagnosis codes such as HCPCS, CPT, Revenue, or ICD-10, and Taxonomy codes billed in accordance with state Medicaid, as well as industry standard guidelines when submitting a claim to Meridian
  - Provider should be familiar with and adhere to the billing guidelines as set forth in the Illinois Association of Medical Health Plans (IAMHP) Billing Guidelines https://iamhp.net/resources/Documents/IAMHP_Billing-Manual_v22_4_21_21%20(1).pdf
- Prior-Authorization – If required, must be submitted via www.ilmeridian.com/providers/preauth-check.html
- Providers must submit and check the status of claims electronically via Meridian's Provider Portal
- The standard submission of Medicaid Claims must be within 180 days of the date of service.
- Adjudication of a claim is based on the benefit coverage and meeting medical necessity criteria and the codes being submitted and considered for review, which can be found on the Illinois Medicaid Fee Schedule: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx

In order to receive reimbursement in a timely manner, please ensure each claim:

- Is submitted according to the timely filing submissions outlined in the provider's Meridian Participating Provider Agreement
- Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service, as well as the corresponding NPI number
- Identifies the patient (member ID number assigned by Meridian, or recipient identification number address, and date of birth)
- Identifies Meridian (plan name and/or ID number)
- Date (mm/dd/yyyy) and place of service and applicable modifiers
- Is for a covered service – See Section 3 of Provider Manual. (Services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD 10CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims)
- If necessary, substantiates the medical necessity and appropriateness of the care or services provided; this includes any applicable authorization number if prior authorization is required by Meridian
- Includes additional documentation based upon services rendered as reasonably required by Meridian Policies
- Is certified by provider that the claim is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information; is certified that the claim identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim
- Is a claim for which the provider has verified the member's eligibility and enrollment in Meridian before the claim was submitted
- Is not a duplicate of a claim submitted within 45 days of the previous submission
- Is submitted in compliance with all of Meridian's prior authorization and claims submission guidelines and procedures
- Is a claim for which provider has exhausted all known other insurance resources
- Is submitted electronically if the provider has the ability to submit claims electronically
- Uses the data elements of UB-04 or CMS 1500 as appropriate
- All laboratory charges should be submitted to Meridian on a CMS 1500

SUBMIT ALL INITIAL CLAIMS FOR ADJUDICATION THROUGH ELECTRONIC CLAIM SUBMISSION OR BY MAIL TO:

For DOS prior to July 1, 2021
MeridianHealth
Attn: Claims Department
1 Campus Martius, Suite 720
Detroit, MI 48226

For DOS on or after July 1, 2021
MeridianHealth
PO Box 4020
Farmington, MO 63640-4402

Timely Filing:

- The standard submission of professional Medicaid claims for both in-network and out-of-network providers is 180 days from the date of service to submit an initial claim.
- The standard submission of institutional Medicaid claims for both in-network and out-of-network providers is 180 days from the discharge date to submit an initial claim.
- Providers have 180 days from the initial claim to resubmit or dispute a claim. There are two exceptions to the timely filing guideline:

o Retroactive eligibility: These claims must be accompanied by documentation demonstrating proof of the eligibility change and must be received within 365 days of notification of the eligibility change
o Third party liability-related delays: These claims must be accompanied by a third party liability (TPL) explanation of benefits and received within 90 days of the TPL process date

For claims not requiring corrections, but the provider is not satisfied with the claim disposition, a claim dispute may be submitted via the Secure Provider Portal at provider.ilmeridian.com (preferred) or via mail. Disputes must be submitted within 90 days from the EOP. All disputes must be received within 365 days of the DOS to be considered for review, unless otherwise specified within the provider contract. If mailing a dispute, please include a Provider Dispute form available at ilmeridian.com. If you chose to mail your dispute, please send it to: MeridianHealth
Attention: Claim Disputes
PO Box 4020
Farmington, MO 63640-4402

If you are replacing or voiding/cancelling a UB-04 claim, please use appropriate bill type of 137 or 138. If you are replacing or voiding/cancelling a CMS 1500 claim, please complete box 22. For replacement or corrected claim, enter resubmission code 7 in the left side of item 22 and enter the original claim number of the claim you are replacing in the right side of item 22. If submitting a void/cancel claim, enter resubmission code 8 in the left side of item 22 and enter the original claim number of the paid claim you are voiding/canceling in the right side of item 22.

Meridian uses claims editing software programs to assist in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and regulations. These software programs may result in claim edits for specific procedure code combinations.

Explanation of Benefits (EOB)

Meridian sends its providers Remittance Advice as a method of explanation of benefits.

Balance billing: When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for the difference between the provider's charge and the Medicaid payment for service.

Encounter Billing Guidelines – ERC, FQHC, and RHC

Meridian requires that ERC, FQHC, and RHC providers submit claims on a CMS 1500 form using the Encounter Code T1015 for medical services or behavioral health services including required modifiers. All services provided during the encounter visit need to be a line item listed below the Encounter Code as a detail code on the claim using the appropriate E/M CPT Code(s).

Electronic Claims Submission

Date of Service	Heath Plan Name	Payer ID
On or before Dec. 31, 2020	MeridianTotal	680069
	MeridianComplete	13189
	MeridianHealth Illinois	13189
On or after Jan. 1, 2021	MeridianComplete	MHPIL
	MeridianHealth Illinois	13189
On or after July 1, 2021	MeridianHealth Illinois	MHPIL

For DOS prior to 7/1/2021, please submit claims with Payer ID 13189 for MeridianHealth via established clearinghouses.

For DOS on or after 7/1/2021, please submit claims with Payer ID MHPIL via our direct connection clearinghouse, Availity.

Availity
Customer Support: 800-282-4548
www.availity.com

Special instructions: PROFESSIONAL – PIN must be the NPI #. FACILITY – Use the NPI # for provider ID (Locator 51), attending physician ID (Locator 82), and the other physician ID (Locator 83).

Providers using electronic submission shall submit all claims to Meridian or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format or a CMS 1500 and/or UB-04, or their successors. Claims shall include the provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim.

Grievances and Appeals

Meridian provides information about the grievance and appeals procedures to all plan members annually and at the time of enrollment. The Member Handbook will explain how member grievances can be initiated. If a member is denied authorization for treatment, Meridian sends written notification to the member. This letter contains information concerning the denial and clearly explains to the member their appeal rights, including how to file an appeal.

Member Grievances

A grievance is any member expression of dissatisfaction, including complaints, directed to Meridian about any matter other than an administrative action that can be appealed. For example:

- A member cannot get an appointment with their doctor in a timely manner
- A member cannot get a referral from their doctor in a timely manner
- A member has been denied any of their rights as a MeridianHealth member
- The quality of care or services received by the member was not satisfactory

For information regarding the Meridian grievance process or if they wish to file a grievance, members or their authorized representative should call the Member and Provider Services department at 866-606-3700, or by writing to the Meridian Grievance department at:

MeridianHealth
Grievance Coordinator
PO Box 44287
Detroit, MI 48244
Fax: 833-669-1734

Meridian will validate and acknowledge the grievance within 48 hours of receipt. The matter will then be reviewed by our Grievance Coordinator. Meridian will thoroughly investigate the grievance and the member will receive a response from the Grievance Coordinator within 90 days.

Member Appeals

An appeal is a request for review of a decision made by Meridian to deny, reduce, or terminate a requested service. A few examples are:

- A service was denied based upon medical necessity
- A payment was denied (in whole or part) for a service
- A service was denied (such as physical therapy) that was previously authorized

Members have 60 days to file an appeal from the date of the denied service. All written or verbal communication by a member regarding dissatisfaction with a decision to deny, reduce or terminate a clinical service based on medical necessity or on benefit determination is to be considered an appeal.

A provider or other authorized representative of the member such as a family member, friend or attorney may file an appeal on the member's behalf with the member's written permission. The member must submit written permission to Meridian for an authorized representative to appeal on their behalf.

Members can appeal by calling Member and Provider Services toll-free at 866-606-3700 or by writing to the Meridian Appeals department at:

MeridianHealth
Attention: Appeals
PO Box 4020
Farmington, MO 63640-4402

If the appeal is filed over the phone, it must be followed by a written signed appeal request. Within three business days of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about the appeal and notify the member and their PCP, as well as any other providers involved in the appeal in writing within 15 business days of receiving all required information.

If a member files for continuation of benefits on or before the latter of 10 days of Meridian sending notice of action, or the intended effective date of the proposed Adverse Benefit Determination, Meridian must continue the member's benefits during the appeal process. A provider, serving as member's authorized representative for the appeal process, cannot file for continuation of benefits. If the final resolution of the appeal is adverse to the member, Meridian may recover the cost of the services that were furnished to the member.

Member Expedited Appeal

If a member or their provider thinks that their situation is clinically urgent and reviewing the appeal in the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the member's medical condition, or would subject the member to severe pain that cannot be adequately managed without the care or treatment, they may call Member and Provider Services at 866-606-3700 to file an expedited appeal. A member will need confirmation from their provider that the appeal is urgent. Within 24 hours of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about the appeal within 24 hours of receiving all required information.

The member and their PCP, as well as any other provider involved in the appeal, will be notified verbally of the outcome of the appeal. A written notification will follow.

Medicaid External Independent Review of Appeals (Home and Community Based Services excluded)

If the appeal regarding medical services is denied, members have the right to request an external independent review. This request can be filed by any of the parties involved in the initial appeal and must be submitted in writing. Members must request an external independent review within 30 days of Meridian's notification of the appeal decision.

The address to file a request for an external independent review is:
MeridianHealth
ATTN: Appeals Department
PO Box 44287
Detroit, MI 48244
Fax: 833-383-1503

Within 30 days of receiving the request, Meridian will make arrangements to select an external reviewer and forward all information to that person. Members have the right to participate in the selection of the external independent reviewer. The reviewer will be a clinical peer with the same or like specialty as the treating provider. The reviewer will have no direct financial interest in connection with the case, and the reviewer will not know the member's identity.

The right to request an external independent review process is reserved for members only after an initial prior request or prior authorization is denied. The external independent review is not available for providers regarding claims payment, handling, or reimbursement for Covered Services. Meridian will not consider external independent review requests by providers made on behalf of members after services are rendered.

The reviewer will make a decision about the appeal within five days of receiving all required information.

Medicaid Expedited External Independent Review of Appeals (Home and Community Based Services excluded)

If the member's situation is clinically urgent, the member or a provider acting on the behalf of the member may call Meridian's Member and Provider Services department at 866-606-3700 to file an urgent request for external independent review. Members will need confirmation from their provider to do this.

The reviewer will make a decision within 24 hours of receiving all required information. The member and their PCP, as well as any other provider involved in the case will be notified verbally of the outcome of the appeal. A written notification will follow.

The address to file a request for an expedited external independent review is:

MeridianHealth
ATTN: Appeals Coordinator
PO Box 44287
Detroit, MI, 48244
Fax: 833-383-1503

State Fair Hearing

At any time, within 120 days of receipt of the Decision Notice from the health plan, the member may request a Fair Hearing. If the member wants to continue to receive services that were previously approved, they must ask for a State Fair Hearing Appeal within 10 calendar days of the date on the Decision Notice. The member may be responsible for paying for the services provided during the appeal process.

If the member or their authorized representative wants to file a State Fair Hearing Appeal related to medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, they can submit their request in writing to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL, 60602
Fax: 312-793-2005
Email: HFS.FairHearings@illinois.govOr call 855-418-4421, TTY: 800-526-5812

If the member or their authorized representative wants to file a State Fair Hearing Appeal related to mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services, or any Home Services Program (HSP) service, they can submit their request in writing to:

Illinois Department of Human Services
Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL, 60602
Fax: 312-793-8573
Email: DHS.HSPAppeals@illinois.gov
Or call 800-435-0774, TTY: 877-734-7429

Section 7: Coordination of Benefits (COB)

Overview

Meridian appreciates your assistance and cooperation in notifying us when any other coverage exists, such as, but not limited to, other healthcare plans and worker's compensation benefits. In the event that Meridian is not the only insurance coverage for the member, Meridian should be billed as secondary payer for all services rendered and is responsible only for the difference between what the primary insurance pays and the allowable Medicaid fee schedule. Please submit claims that have other insurance payers to Meridian with an attached explanation of benefits (EOB) payment or rejection.

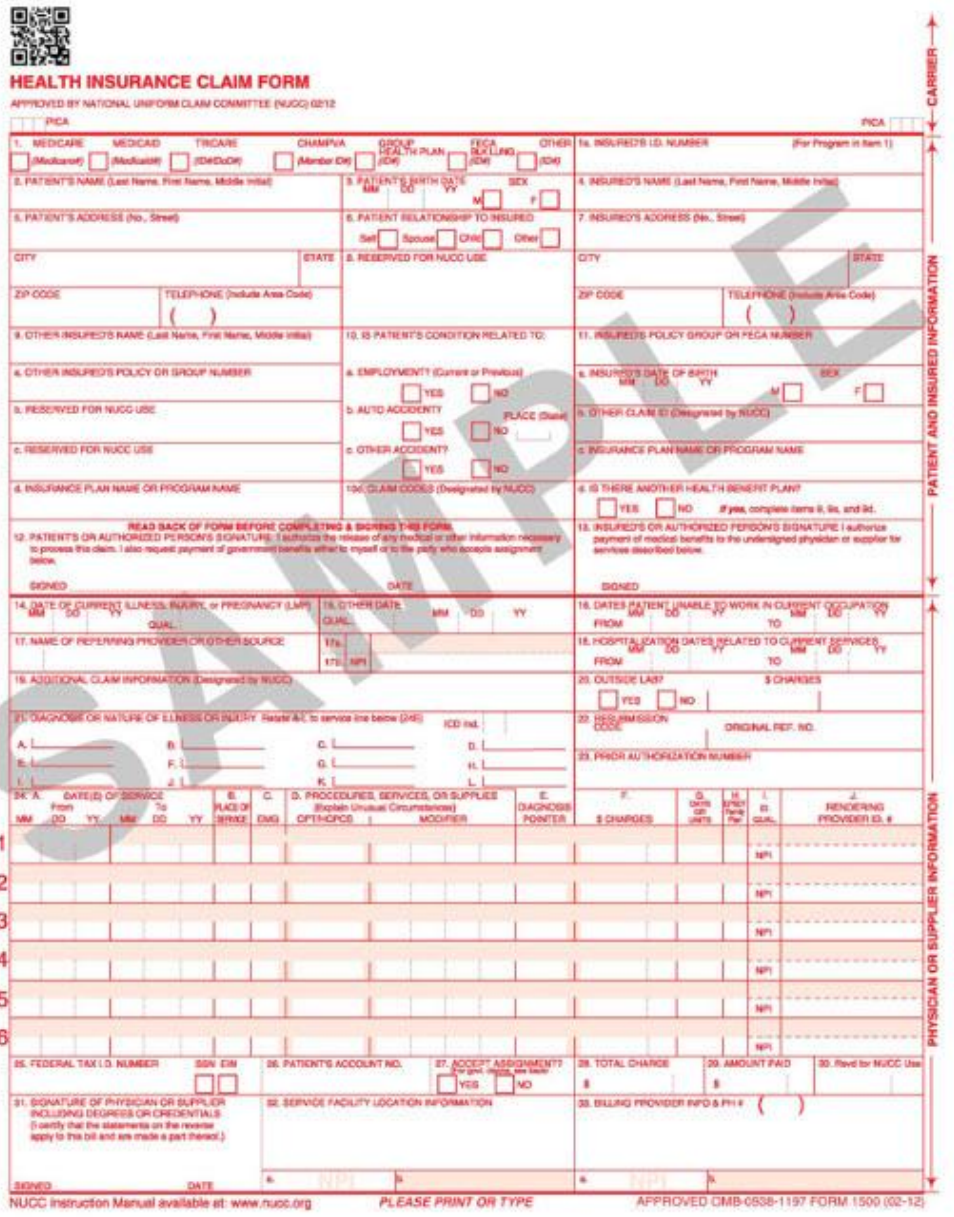
Claims Guidelines for Dual-Eligible Members

Services provided to patients who are covered by Meridian for both Medicare and Medicaid should follow the guidelines below:

- Submit one authorization request – Meridian will coordinate authorization requirements, benefits, and services between the two products
- Submit one claim to Meridian – There is no need to submit two claims. Claims processing information will be reported on two Remittance Advice (RA) forms:
  - The first Remittance Advice will come from Meridian Medicare indicating how the claim was processed and informing you that the claim was forwarded to Meridian Medicaid for secondary processing
  - The second Remittance Advice will show how the claim was processed for Meridian Medicaid

Appendix I: Sample CMS 1500 and UB-04 Forms

CLAIMS FORM INSTRUCTIONS CMS 1500 CMS 1500 (2/12) Claim Form Instructions



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Key: R =Required S =Situational (Only if appropriate to this claim) NR= Not Required

Form Number	Requirement	Form Label	Specifics
1	R	Type of Health Insurance Coverage	Select the correct type of coverage.
1a	R	Insured ID Number	Enter the member's ID number from the Meridian ID card
1	R	Patient's Name	Enter the patient's last name, first name and middle initial
2	R	Patient's Birth Date/Sex	Enter the patient's date of birth using the eight-digit format (MM/DD/YY). Next, select the patient's gender.
3	R	Insured's Name	Enter the insured's last name, first name and middle initial.
4	R	Patient's Address/Telephone Number	Enter the patient's permanent mailing address and telephone number
5	R	Patient's Relationship To The Insured	Select the appropriate box for the patient's relationship to the insured person.
6	R	Insured's Address/Telephone Number	Enter the insured person's permanent mailing address (complete if different from the patient's address)
7	S	Reserved for NUCC Use	
9	NR	Other Insured's Name	Enter the other insured person's last name, first name and middle initial. When the patient has other insurance coverage, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.
9a	S	Other Insured's Policy or Group Number	Enter the other insured person's policy or group number.
9b	NR	Reserved For NUCC Use	Enter the insured person's date of birth using the eight-digit format (MM/DD/YY).
9c	NR	Reserved for NUCC Use	Enter the other insured person's employer or school name.
9d	S	Insurance Plan Name or Program Name	Enter the name of the other insured person's insurance plan or program name.
10a-d	S	Is Patient's Condition Related	For 10a-10d, required status is

		To:	contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank.
10a	S		Select whether the patient's condition is related to employment
10b	S		Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation, i.e. MI.
10c	S		Select whether the patient's condition is related to any other type of accident.
10d	NR	Claim Codes (Designated by NUCC)	Not Required.
11	R	Insured's Policy Group or FECA number	Not Required
11a	R	Insured's Date of Birth /Gender	Enter the subscriber's date of birth using the eight-digit date format (MM/DD/YY) and select the subscriber's gender.
12	NR	Patient or Authorized Person's Signature	Not Required
13	NR	Insured or Authorized Person's Signature	Not Required
14	S	Date of Current Illness, Injury, or Pregnancy (LMP)	Enter the date using an eight-digit date format (MM/DD/YY).
15	S	Other Date	Enter the date using an eight-digit date format (MM/DD/YY).
16	S	Dates Patient Unable to Work in Current Occupation.	Enter the date using an eight-digit date format (MM/DD/YY).
17	S	Name of Referring Provider or Other Source	Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials.
17a	NR	Other ID#	Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).
17b	S	NPI#	Enter the 10-digit NPI number of the referring, ordering or supervising provider.
18	S	Hospital Dates Related to Current Services	Enter the hospital dates using an eight-digit date format (MM/DD/YY).
19	NR	Additional Claim Information	Not required.

20	R	Outside Lab / Charges	Select “Yes” or “No” to indicate if the claim includes charges for lab services performed outside of the physician’s office. If “Yes”, enter the total charges.
21	R	Diagnosis or Nature of Illness or Injury	Enter the ICD-10 CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. Up to three additional diagnosis codes can be entered.
22	NR	Resubmission	Not required.
23	NR	Prior Authorization Number	Not required.
24		Shaded Area – Supplemental Information	The shaded area of field 24a-24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee’s website at www.nucc.org.
24	R	Date(s) of Service	Enter the dates of service using an eight-digit date format (MM/DD/YY).
24B	R	Place of Service	Enter the appropriate two-digit Place of Service code.
24C	S	EMG	If this service was an emergency, enter “Y” for “Yes,” or leave blank if “No”.
24D	R	Procedures, Services, or Supplies	Enter the CPT or HCPCS code for the procedures, services or supplies, and enter a modifier if applicable.
24E	R	Diagnosis Pointer	Enter the appropriate ICD-10 CM diagnosis code or codes for each procedure performed. Enter one code per line of service.
24F	R	Charges	Enter the charge for each line of service. Do not include discounts.
24G	R	Days or Units	Enter the number of days or units for each line of service.
24H	S	EPSDT/Family Plan	If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or

			family planning (FP) code.
24I	NR	ID Qualifier – Shaded Field	Not Required
24J	R	Rendering Provider ID # Shaded Field	Required Enter the provider's taxonomy code
25	R	Federal Tax ID Number	Enter the Federal Tax ID Number for the provider of service. Select the appropriate field for SSN or EIN.
26	S	Patient Account Number	Enter account number assigned to the patient if applicable.
27	R	Accept Assignment	Select "Yes" if the provider should be paid, or select "No" if the patient should be paid.
28	R	Total Charge	Enter the total charge for all services.
29	S	Amount Paid	Enter any amount paid by the patient only.
30	NR	RSVD for NUCC Use	Enter the difference, if any, between the total charge and the amount paid.
31	R	Signature of Physician or Supplier Include Degrees or Credentials	The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated using an eight-digit date format (MM/DD/YY)
32	S	Service Facility Location Information	Enter the location where the services were rendered. The provider of service must identify the supplier's information when billing for purchased diagnostic tests.
32a	S	NPI	Enter the 10-digit NPI number of the service facility location.
32b	NR	Other ID#	Not required
33	R	Billing Provider Info and PH#	Enter the information of the billing provider or supplier to be paid for services.
33a	R	NPI	Enter the 10-digit NPI number of the billing provider.
33b	NR	Other ID#	Not required

UB-04 Claim Form Example

Key: R =Required S =Situational (Only if appropriate to this claim) NR = Not Required

Form Number	Requirements	Form Label	Specifics
1	R	Billing Provider Name, Address & Telephone Number	Enter the billing name, street address, city, state, zip code and telephone number of the billing provider submitting the claim. Note: this should be the facility address.
2	S	Pay to Name and Address	Enter the name, street address, city, state, and zip code where the provider submitting the claims intends payment to be sent. Note: This is required when information is different from the billing provider's information in form number 1.
3A	R	Patient Control Number	Enter the patient's unique alphanumeric control number assigned to the patient by the provider.
3B	S	Medical Record Number	Enter the number assigned to the patient's medical health record by the provider.
4	R	Type of Bill	Enter the appropriate code that indicates the specific type of bill such as inpatient, outpatient, late charges, etc. For more information on Type of Bill, refer to the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual.
5	R	Federal Tax Number	Enter the provider's Federal Tax Identification number.
6	R	Statement Covers Period (From/Through)	Enter the beginning and ending service dates of the period included on the bill using a six-digit date format (MMDDYY). For example: 010107.
7	NR		Reserved for assignment by the NUBC. Providers do not use this field.
8A	S	Patient Name/Identifier	Enter the patient's identifier. Note: The patient identifier is situational/conditional, if different than what is in form

			number 60 (Insured's Subscriber/Insured's Identifier).
8B	R	Patient Name	Enter the patient's last name, first name and middle initial.
9	R	Patient Address	Enter the patient's complete mailing address (fields 9a – 9e), including street address (9a), city (9b), state (9c), zip code (9d) and country code (9e), if applicable to the claim.
10	R	Patient Birth Date	Enter the patient's date of birth using an eight-digit date format (MMDDYY). For example: 01281970.
11	R	Patient Sex	Enter the patient's gender using an "F" for female, "M" for male or "U" for unknown.
12	S	Admission/Start of Care Date (MMDDYY)	Enter the start date for this episode of care using a six-digit format (MMDDYY). For inpatient services, this is the date of admission. For other (Home Health) services, it is the date the episode of care began. Note: This is required on all inpatient claims.
13	S	Admission Hour	Enter the appropriate two-digit admission code referring to the hour during which the patient was admitted. Note: Required on all inpatient claims, except TOB 021X. For more information on Admission Hour, refer to the NUBC's Official UB-04 Data Specifications Manual.
14	R	Priority (Type) of Visit	Enter the appropriate code indicating the priority of this admission/visit. For more information on Priority (Type) of Visit, refer to the NUBC's Official UB-04 Data Specifications Manual.
15	R	Point of Origin for Admission or Visit	Enter the appropriate code indicating the point of patient origin for this admission or visit. For more information on Point

			of Origin for Admission or Visit, refer to the NUBC's Official UB-04 Data Specifications Manual.
16	S	Discharge Hour	Enter the appropriate two-digit discharge code referring to the hour during which the patient was discharged. Note: Required on all final inpatient claims.
17	R	Patient Discharge Status	Enter the appropriate two-digit code indicating the patient's discharge status. Note: Required on all inpatient, observation, or emergency room care claims.
18-28	S	Condition Codes	Enter the appropriate two-digit condition code or codes if applicable to the patient's condition.
29	S	Accident State	Enter the appropriate two-digit state abbreviation where the auto accident occurred, if applicable to the claim.
30	NR		Reserved for assignment by the NUBC. Providers do not use this field.
31-34	S	Occurrence Codes/Dates (MMDDYY)	Enter the appropriate two-digit occurrence codes and associated dates using a six-digit format (MMDDYY), if there is an occurrence code appropriate to the patient's condition.
35-36	S	Occurrence Span Codes/Dates (From/Through) (MMDDYY)	Enter the appropriate two-digit occurrence span codes and related from/through dates using a six-digit format (MMDDYY) that identifies an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time.
37	NR		Reserved for assignment by the NUBC. Providers do not use this field.
38	S	Responsible Party Name and Address (Claim Addressee)	Enter the name, address, city, state and zip code of the party responsible for the bill.
39-41	S	Value Codes and Amount	Enter the appropriate two-digit value code and value if there is a

			value code and value appropriate for this claim.
42	R	Revenue Code	Enter the applicable Revenue Code for the services rendered. For more information on Revenue Codes, refer to the NUBC's Official UB-04 Data Specifications Manual.
43	R	Revenue Description	Enter the standard abbreviated description of the related revenue code categories included on this bill. (See Form Number 42 for description of each revenue code category.) Note: The standard abbreviated description should correspond with the Revenue Codes as defined by the NUBC. For more information on Revenue Description, refer to the NUBC's Official UB-04 Data Specifications Manual.
44	S	HCPCS/Rates/HIPPS Code	Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. Also report HCPCS modifiers when a modifier clarifies or improves the reporting accuracy. HCPCS and HIPPS Rate Codes: Situational. Required for outpatient claims when an appropriate HCPCS code exists for this service line item. Accommodation Rates: Situational. Required when a room & board revenue code is reported. HCPCS Modifiers: Situational. Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.
45	S	Service Date (MMDDYY)	Enter the applicable six-digit format (MMDDYY) for the service line item if the claim was for outpatient services, SNF\Prospective Payment

			System assessment date, or needed to report the creation date for line 23. For more information on Service Dates, refer to the NUBC's Official UB-04 Data Specifications Manual.
46	R	Service Units	Enter the number of units provided for the service line item.
47	R	Total Charges	Enter the total charges using Revenue Code 0001. Total charges include both covered and non-covered services. For more information on Total charges, refer to the NUBC's Official UB-04 Data Specifications Manual.
48	S	Non-Covered Charges	Enter any non-covered charges as it pertains to related Revenue Code. For more information on Non-Covered Charges, refer to the NUBC's Official UB-04 Data Specifications Manual.
49	NR		Reserved for assignment by the NUBC. Providers do not use this field.
50	R	Payer Name	Enter the health plan that the provider might expect some payment from for the claim.
51	R	Health Plan Identification Number	Enter the number used by the primary (51a) health plan to identify itself. Enter a secondary (51b) or tertiary (51c) health plan, if applicable.
52	R	Release of Information	Enter a "Y" or "I" to indicate if the provider has a signed statement on file from the patient or patient's legal representative allowing the provider to release information to the carrier.
53	R	Assignment of Benefits	Enter a "Y", "N" or "W" to indicate if the provider has a signed statement on file from the patient or patient's legal representative assigning payment to the provider for the

			primary payer (53a). Enter a secondary (53b) or tertiary (53c) payer, if applicable.
54	S	Prior Payments	Enter the amount of payment the provider has received (to date) from the payer toward payment of the claim.
55	S	Estimated Amount Due	Enter the amount estimated by the provider to be due from the payer.
56	R	National Provider Identifier (NPI)	Enter the billing provider's 10-digit NPI number.
57	S	Other Provider Identifier	Required on or after the mandated NPI Implementation date when NPI is not used in FL 56 and an identification number other than the NPI is necessary to identify the provider.
58	R	Insured's Name	Enter the name of the individual (primary – 58a) under whose name the insurance is carried. Enter the other insured's name when other payers are known to be involved (58b and 58c).
59	R	Patient's Relationship to Insured	Enter the appropriate two-digit code (59a) to describe the patient's relationship to the insured. If applicable, enter the appropriate two-digit code to describe the patient's relationship to the insured when other payers are involved (59b and 59c).
60	R	Insured's Unique Identifier	Enter the insured's identification number (60a). If applicable, enter the other insured's identification number when other payers are known to be involved (60b and 60c).
61	S	Insured's Group Name	Enter insured's employer group name (61a). If applicable, enter other insured's employer group names when other payers are known to be involved (61b and 61c).
62	R	Insured's Group Number	Enter insured's employer group number (62a). If applicable,

			enter other insured's employer group numbers when other payers are known to be involved (62b and 62c).
63	S	Treatment Authorization Codes	Enter the pre-authorization for treatment code assigned by the primary payer (63a). If applicable, enter the pre-authorization for treatment code assigned by the secondary and tertiary payer (63b and 63c).
64	S	Document Control Number (DCN)	Enter if this is a void or replacement bill to a previously adjudicated claim (64a – 64c).
65	S	Employer Name	Enter when the employer of the insured is known to potentially be involved in paying claims. For more information on Employer Name, refer to the NUBC's Official UB-04 Data Specifications Manual.
66	R	Diagnosis and Procedure Code Qualifier	Enter the required value of "9." Note: "0" is allowed if ICD-10 is named as an allowable code set under HIPAA. For more information, refer to the NUBC's Official UB-04 Data Specifications Manual.
67	R	Principal Diagnosis Code and Present on Admission Indicator	Enter the principal diagnosis code for the patient's condition. For more information on POAs, refer to the NUBC's Official UB-04 Data Specifications Manual.
67A-67Q	S	Other Diagnosis Codes	Enter additional diagnosis codes if more than one diagnosis code applies to claim.
68	NR		Reserved for assignment by the NUBC. Providers do not use this field.
69	S	Admitting Diagnosis Code	Required when a claim involves an inpatient admission.
70	S	Patient's Reason for Visit	Enter the appropriate reason for visit code only for bill types 013X and 085X and 045X, 0516, 0526, or 0762 (observation room).
71	S	Prospective Payment System	Enter the DRG based on

		(PPS) Code	software for inpatient claims when required under contract grouper with a payer.
72	S	External Cause of Injury (ECI) Code	Enter the cause of injury code or codes when injury, poisoning or adverse effect is the cause for seeking medical care.
73	NR		Reserved for assignment by the NUBC. Providers do not use this field.
74	S	Principal Procedure Code and Date (MMDDYY)	Enter the principal procedure code and date using a six-digit format (MMDDYY) if the patient has undergone an inpatient procedure. Note: Required on inpatient claims.
74A-E	S	Other Procedure Codes and Dates (MMDDYY)	Enter the other procedure codes and dates using a six-digit format (MMDDYY) if the patient has undergone additional inpatient procedure. Note: Required on inpatient claims.
75	NR		Reserved for assignment by the NUBC. Providers do not use this field.
76	S	Attending Provider Name and Identifiers	Enter the attending provider's NPI number, last name and first name. Situational: Not required for non-scheduled transportation claims. For more information on Attending Provider, refer to the NUBC's Official UB-04 Data Specifications Manual.
77	S	Operating Provider Name and Identifiers	Enter the operating provider's NPI number, last name and first name. Required when a surgical procedure code is listed on the claim. For more information on Operating Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.
78-79	S	Other Provider Name and Identifiers	Enter any other provider's NPI number, last name and first

			name. For more information on Other Provider, refer to the NUBC's Official UB-04 Data Specifications Manual.
80	S	Remarks	Enter any information that the provider deems appropriate to share that is not supported elsewhere.
81CC A-D	S	Code-Code Field	Report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. Note: To further identify the billing provider (FL01), enter the taxonomy code along with the "B3" qualifier. For more information on requirements for Form Number 81, refer to the NUBC's Official UB-04 Data Specifications Manual.
Line 23			Line 23 contains an incrementing page and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

Appendix II: Third Party Coverage

Topic	Description
Identification of Third Party Resources	Providers must always identify third party resources and report third party payments in the appropriate item(s) on the claim. Third party resources must be identified even when the payer does not cover the services.
Commercial Insurance Payments	If payments are made by a commercial insurance, the EOB must be submitted with the claim.
Medicaid Deductible	If the beneficiary's Medicaid deductible amount is met in the middle of a service so that part of the charge is the beneficiary's responsibility and part is Medicaid's responsibility, enter the remaining Medicaid liability for the service in item 24F of the service line.
Evidence of Other Insurance Response	When billing on the CMS 1500 paper claim form, providers must submit evidence of other insurance responses (EOBs, denials, etc.) when billing for covered services. If billing electronically, no EOB is necessary, as all required data are part of the electronic format. However, in all cases where a provider is billing on the CMS 1500 claim form, a copy of the Medicare EOB must be submitted with the claim.
Injectable Drugs Covered as a Pharmacy Benefit by Third Party Payers	When billing for injectable drugs that are covered as a pharmacy benefit by a third party payer but covered as a physician service by Medicaid, the provider must reflect the payment from the carrier on the claim. The fixed copay/coinsurance/deductible must be reported in the appropriate field on the electronic claim form and in Item 24F on the CMS 1500 paper form.