Provider Billing and Claims Guide

Humana
Healthy Horizons®
in South Carolina

Healthy Connections

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Medical claims payment policy disclaimer

The intended audience of this Provider Billing and Claims Guide is healthcare providers who treat patients with Humana Healthy Horizons® in South Carolina coverage. These policies are made available to provide information about certain Humana claims payment processes. These policies are guidelines only and do not constitute a benefit determination, medical advice, guarantee of payment, plan preauthorization, an Explanation of Benefits (EOB) or a contract. These policies are not intended to address every claim situation. Whether a procedure is covered shall be determined based on the terms and provisions of a specific member plan or policy. Claims may be affected by other factors, such as state and federal laws and regulations, provider contract terms, and our professional judgment. These policies are subject to change or termination by Humana. Humana has full and final discretionary authority for their interpretation and application.

Claims Resources for Providers - Humana is the ultimate resource and offers a wealth of information to assist you with claims, authorization requests, reimbursement, coding issues, etc. However, we have put together a quick reference guide to assist you with the most common claims and billing issues you may encounter.

Claim submission

Claims, including corrected claims, must be submitted within 1 year from the date of service or discharge.

Humana Healthy Horizons does not pay claims with incomplete, incorrect or unclear information. Healthcare providers have 30 calendar days from the date of service or discharge to submit a claim dispute.

All claims (electronic and paper) must include:

- Patient (member) name
- Patient address
- Member's ID number: Be sure to provide the complete Humana Healthy Horizons member ID from the patient.
- Patient's date of birth: Always include the member's date of birth so we can identify the correct person in case we have more than 1 member with the same name.
- Place of service: Use standard Centers for Medicare & Medicaid Services (CMS) location codes.
- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) diagnosis code(s)
- Health Insurance Portability and Accountability Act (HIPAA)-compliant Current Procedural Terminology (CPT®) Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers when applicable.
- Units, where applicable (e.g., anesthesia claims require number of minutes)
- Date of service for professional services: Please include dates for each service rendered. Date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.

- Prior authorization number, when applicable: A number is needed to match the claim to the corresponding prior authorization information. This is only needed if the service provided required a prior authorization.
- National Provider Identifier (NPI): Please refer to the location of the provider NPI, Tax Identification Number (TIN) and member ID number section.
- Federal TIN or physician Social Security number (SSN): Every provider practice (i.e., legal business entity) has a different TIN.
- Billing and rendering addresses that match the South Carolina Department of Health and Human Services (SCDHHS) Master Provider Listing (MPL)
- Signature of physician or supplier: The provider's complete name should be included. If we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

Electronic funds transfer/electronic remittance advice

Electronic claim payment offers several advantages over traditional paper checks:

- Faster payment processing
- Access to online or electronic remittance information
- Eliminated risk of lost or stolen checks

With electronic funds transfer (EFT), your Humana claims payments are deposited directly into the bank account(s) of your choice. You will also be enrolled for our electronic remittance advice (ERA), which replaces the paper version of your explanation of remittance.

NOTE: Fees may be associated with electronic transactions. Please check with your financial institution or merchant processor for specific rates related to EFT or credit card payments. Check with your clearinghouse for fees associated with ERA transactions.

EFT/ERA enrollment through Humana Healthy Horizons in South Carolina

Get paid faster and reduce administrative paperwork with EFT and ERA.

Physicians and other healthcare providers can utilize the Humana Healthy Horizons EFT/ERA enrollment tool on Availity Essentials to enroll.

To access this tool:

1. Sign in to Availity Essentials at Availity.com (registration required).
2. From the Payer Spaces menu, select Humana.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator to discuss your need for this tool.)

EFT payment transactions are reported with file format CCD+, which is the recommended industry standard for EFT payments. The CCD+ format is a National Automated Clearing House Association corporate payment format with a single, 80-character addendum record capability. The addendum record is used by the originator to provide additional information about the payment to the recipient.

This format is also referenced in the ERA (825 data file). Contact your financial institution if you would like to receive this information.

The ERA replaces the paper version of the External Quality Review (EQR). Humana Healthy Horizons delivers 5010 835 versions of all ERA remittance files that are HIPAA-compliant. Humana Healthy Horizons uses Availity as the central gateway for delivery of 835 transactions. You can access your ERA through your clearinghouse or through the secure provider tools available in **Availity Essentials**, which open in a new window.

Submitting electronic transactions

As a secure provider portal, Availity Essentials offers convenient self-service tools for working online with multiple payers, including Humana Healthy Horizons. Available features include:

- Eligibility and benefits lookup
- Member summary access
- Referrals and authorizations submission and review
- Claim status lookup
- Claim submission
- Remittance advice access
- Claim dispute submission and management
- Medical records submission and management
- Overpayment management
- Electronic remittance advice/electronic funds transfer enrollment and management

To learn more, call **800-282-4548** or visit **Availity.com**.

To submit claims electronically, providers must work with an electronic claim clearinghouse. Humana Healthy Horizons currently accepts electronic claims from South Carolina providers through various clearinghouses.

When filing an electronic claim, you will need to use 1 of the following payer IDs:

- 61101 for fee-for-service claims
- 61102 for encounter claims

Unlisted CPT/HCPCS codes

If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPSC procedure code on the claim form:

- A full, detailed description of the service provided
- A report, such as an operative report or a plan of treatment
- Other information that would assist in determining the service rendered

As an example, code 84999 is an unlisted lab code that requires additional explanation.

NPI, TIN and taxonomy

Your NPI and TIN are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., FQHC, RHC and/or primary care center) using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered.

SCDHHS requires all NPIs, billing and rendering addresses, and taxonomy codes be present on its MPL. Claims submitted without these numbers or with information that is not consistent with the MPL are rejected. Please contact your electronic data interchange (EDI) clearinghouse if you have questions on where to use the NPI, TIN or taxonomy numbers on the electronic claim form you submit.

Effective Aug. 1, 2018, SCDHHS updated billing provider taxonomy claim requirements for the following provider types:

- Federally Qualified Health Centers, provider type 31 with specialty code 080
- Rural Health Centers, provider type 35

If billing providers have only 1 taxonomy linked to their SCDHHS MPL NPI, then their claims do not need to include taxonomy. Taxonomy is still required for the following:

- Billing providers who have multiple taxonomies linked to their NPI on the SCDHHS MPL
- All rendering providers

If your NPI and taxonomy codes change, please ensure you update your taxonomy information with Humana Healthy Horizons and the SCDHHS MPL. Please contact Humana Healthy Horizons in South Carolina Provider Services at **866-432-0001** or your provider relations representative to update your demographic information.

Location of provider NPI, TIN and member ID number

Humana Healthy Horizons accepts electronic claims in the 837 ANSI ASC X12N (005010A1) file format for both professional and hospital claims.

On 5010 (8337P) professional claims:

The provider NPI should be in the following location:

- 2010AA Loop - Billing provider name
- Identification code qualifier- NM108 = XX
- Identification code - NM109 = Billing provider NPI
- 2310B Loop - Rendering provider name
- Identification code – NM109 = Rendering provider NPI
- For form CMS-1500, the rendering provider taxonomy code in box 24J
- ZZ qualifier in box 24I for rendering provider taxonomy

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the employer identification number (EIN) for organizations or the Social Security number for individuals:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN
- The billing provider taxonomy code in box 33b

On 5010 (837I) institutional claims, the billing provider NPI should be in the following location:

- 2010AA Loop = Billing provider name
- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the EIN for organizations or the SSN for individuals:

- Reference identification qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference identification – REF02 = Billing provider TIN or SSN
- The billing taxonomy code goes in box 81

On all electronic claims, the Humana Healthy Horizons member ID number should go on:

- 2010BA Loop = Subscriber name
- NM109 = Member ID number

Paper claim submissions

For the most efficient processing of your claims, Humana Healthy Horizons recommends you submit all claims electronically. If you submit paper claims, please use 1 of the following claim forms:

- CMS-1500, formerly HCFA 1500 form — AMA universal claim form also known as the National Standard Format (NSF)
- CMS-1450 (UB-04), formerly UB92 form, for facilities paper claim submission must be done using the most current form version as designated by CMS and the National Uniform Claim Committee (NUCC).

Please mail all paper claim forms to Humana Healthy Horizons at the following address:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Humana Healthy Horizons uses optical/intelligent character recognition systems to capture claims information to increase efficiency and to improve accuracy and turnaround time. We cannot accept handwritten claims or super bills. Humana Healthy Horizons also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plan organizations. Local or proprietary codes are no longer allowed.

Instructions for National Drug Code on paper claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable), the 11-digit National Drug Code (NDC) (this excludes the N4 qualifier), a unit of measurement code (F2, GR, ML or UN are the only acceptable codes), and the metric decimal or unit quantity that follows the unit of measurement code.
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity.
- Do not enter hyphens or spaces with the NDC.
- Use 3 spaces between the NDC and the units on paper forms.

Tips for submitting paper claims

Electronic claims are generally processed more quickly than paper claims. If you submit paper claims, we require the most current form version as designated by CMS and NUCC. No handwritten claims or super bills, including printed claims with handwritten information, will be accepted. Make sure to:

- Use only original claim forms; do not submit claims using forms that have been photocopied or printed from a website.
- Use 10- to 14-point fonts (capital letters preferred) in black ink.
- Avoid liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- Provide federal TIN or physician Social Security number with all claim submissions.

All data must be updated and on file with the SCDHHS MPL, including TIN, billing and rendering NPI, addresses, and taxonomy codes. Coordination of Benefits (COB) paper claims require a copy of the Explanation of Payment (EOP) from the primary carrier.

Out-of-network claims

Humana Healthy Horizons established guidelines for payments to out-of-network providers for preauthorized medically necessary services. These services will be reimbursed, with prior authorization, at 100% of the South Carolina Medicaid fee schedule. If the service is not available from an in-network provider and Humana Healthy Horizons has 3 documented attempts to contract with an out-of-network provider, Humana Healthy Horizons may reimburse that provider less than the Medicaid fee-for-service rate.

Claim processing guidelines

Timely filing

- Healthcare providers have 1 year from the date of service or discharge to submit a claim. If the claim is submitted after the applicable timely filing term, the claim will be denied for timely filing.
- If a member has Medicare and Humana Healthy Horizons is secondary, the provider may submit for secondary payment within 2 years from the date of service or within 6 months from the Medicare adjudication date.
- If a member has other insurance and Humana Healthy Horizons is secondary, it is recommended that the provider submit for secondary payment within 30 days from the other insurance payment date.

Coordination of benefits

- COB requires a copy of the appropriate remittance statement from the primary carrier payment.
- Electronic claims - primary carrier's payment information - Paper claims – EOB from primary carrier.
- Medicare COB claims - Appropriate Remittance Statement must be received within 2 years from the date of service or within 6 months from Medicare adjudication.
- Non-Medicare primary payer – Appropriate remittance statement must be received within 1 year from date of service or discharge.
- If a claim is denied for COB information needed, the provider must submit the appropriate remittance statement from the primary payer within the remainder of the initial claim's timely filing period.

Newborn claims

All claims for newborns must be submitted using the newborn's Humana Healthy Horizons ID number and South Carolina Medicaid ID number.

Newborns shall be deemed eligible for Medicaid and automatically enrolled by the birthing hospital with Humana Healthy Horizons if sent within 3 months of the birth.

This coverage for the mother continues for 12 months after the baby's birth. The infant is covered up to age 1. Do not submit newborn claims using the mother's identification numbers; the claim will be denied. Claims for newborns must include birth weight.

Claims compliance standards

Crossover claims

Humana Healthy Horizons must receive the Medicare EOB with the claim. The claims adjuster reviews to ensure that all fields are completed on the EOB and determines the amount that should be paid out. Crossover claims should not be denied if received within 2 years or 6 months from Medicare adjudication.

Claim status

Providers can track the progress of submitted claims at any time through Availity Essentials. Claim status is updated daily and provides information on claims submitted in the previous 18 months. Searches by member ID number, member name and date of birth, or claim number are available.

You can find the following claim information on the provider portal:

- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnosis
- Claim payment date

Claims payments by Humana Healthy Horizons to providers are accompanied by an itemized accounting of the individual claims in the payment including, but not limited to, the patient's name, the date of service, the procedure code, service units, the reimbursement amount and identification of Humana Healthy Horizons entity.

Humana Healthy Horizons extends each provider the opportunity to meet with a Humana Healthy Horizons representative if it is believed a clean claim remains unpaid in violation of the South Carolina Code of Laws. Additionally, the same opportunity is extended to providers if a claim remains unpaid for more than 45 days after the date the claim was received by Humana Healthy Horizons.

Checks

Paper checks are printed and mailed twice a week, Sundays and Wednesdays.

EDI submissions

All EDI submissions to Humana pass through **Availity Essentials**. A process known as advanced claims editing applies coding rules to a medical claim submitted through the Availity gateway via EDI before the claim enters Humana's claim payment system. This enables a claim submitter to identify potential coding issues up front, and it reduces processing delays that can result from incomplete or inaccurate claim data.

For more information, review please review:

Electronic batch claims experience streamlines: Advanced claims editing (ACE)

The below link provides more information on claim submission:

Claim submissions - Humana

Claim forms

Claims may be submitted on UB-04 for facility services and CMS-1500 for professional services. Below is guidance on how these forms can be completed.

UB-04 claim form required fields

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH 7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Locator fields for the UB-04 claim form

Locator field	Field description	Field definition	Code structure
1	Provider location	Address of the provider including the phone number, fax and country code	N/A
2	Pay to information	Lists the payment information for the provider	
3a 3b	Patient Control and Medical Record Number	Patient's unique alphanumeric number assigned by provider to: • Help with the retrieval of individual financial records • Post the payment	
4	Type of bill	A code indicating the specific type of bill **Examples:** Inpatient, outpatient, changes and voids	
5	Federal Tax Identification Number	The number assigned to the provider by the federal government for tax reporting purposes. Also known as a TIN or employer ID number (EIN).	N/A
6	Statement covers period	Beginning and ending service dates of the period included on this bill	
7	Blank	N/A	
8	Patient ID/name	**8a**: Last name, first name and middle initial of the patient. The Patient ID as assigned by payer when it's different from the insured's ID. **8b**: Last name, first name and middle initial of the patient.	
9	Patient address	Address of the patient as defined by the payer organization	
10	Date of birth	Date of birth of the patient	
11	Sex	Sex of the patient as recorded at date of admission, outpatient service or start of care	Detail
12	Admission date	Date the patient was admitted to the provider for inpatient care or start of care for outpatient services	N/A
13	Admission hour	The hour during which the patient was admitted for inpatient or outpatient care	
14	Admission type	A code indicating the priority of this admission/visit	

Locator field	Field description	Field definition	Code structure
15	Admission source	The code indicating the source of this inpatient admission or outpatient registration	N/A
16	Discharge hour	Hour the patient was discharged from inpatient care	
17	Patient status	A code indicating the patient's status upon discharge	
18 - 28	Condition codes	A code used to identify conditions relating to this bill that can affect payer processing	
29	ACDT state	2-character state abbreviation of where an auto accident occurred	
30	Blank	N/A	N/A
31 - 34	Occurrence code and date	The code and associated date defining a significant event relating to this bill that can affect payer processing	
35 - 36	Occurrence span code, from and through	The code and associated date defining a significant event relating to this bill that can affect payer processing	
37-38	Blank	N/A	
39 - 41	Value codes and amount	A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payer organization	
42	Revenue code	A code that identifies a specific accommodation, ancillary service or billing calculation	
43	Revenue description	A narrative description of the related revenue categories included on this bill; abbreviations can be used **Note:** The description and abbreviations correspond with the revenue codes as defined by the National Uniform Billing Committee (NUBC).	

Locator field	Field description	Field definition	Code structure
44	Healthcare Common Procedure Coding System (HCPCS)/rates/ Health Insurance Prospective Payment System (HIPPS) rate codes	The accommodation rate for inpatient bills and the CMS HCPCS applicable to ancillary service and outpatient bills. The HIPPS rate code consists of the Resource Utilization Group (RUG-III) code. This code is obtained from the Minimum Data Set (MDS) Grouper. A 2-digit modifier is used to indicate the assessment type attributable to the RUG-III code.	N/A
45	Service date	The date the indicated outpatient service was provided on a series bill	N/A
46	Units of service	A measure of services rendered by revenue category to or for the patient to include items **Examples:** Number of accommodation days, miles, pints of blood or renal dialysis treatments	
47	Total billed charges (by revenue code category)	Total billed charges pertaining to the related revenue code for the current billing period as typed in the statement covers period. Total billed charges include both covered and non-covered charges.	
48	Non-covered charges	To reflect non-covered charges for the primary payer pertaining to the related revenue code	
49	Unlabeled	Unlabeled fields are reserved for state and national use. State-use fields can be assigned at the state level after negotiation with the payers and providers involved. National-use fields are reserved for national assignment.	
50	Payer name	Name of each payer organization from which the provider can expect some payment for this bill	**A:** Primary Payer **B:** Secondary Payer **C:** Tertiary Payer
51	Health plan ID	The number assigned to the provider by the payer indicated in field **50**	

Locator field	Field description	Field definition	Code structure
52	Release of Information Certification Indicator	A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations for processing the claim	**Y:** Yes, the hospital has signed written authority to release medical/ billing information for purposes of claiming insurance benefits. **R:** Restricted, the hospital has limited or restricted authority to release some medical/ billing information for purposes of claiming insurance benefits. **N:** No release, the hospital does not have permission to release any medical/billing information.
53	Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the third-party payer to pay the provider	**Y:** Yes, benefits assigned. **N:** No, benefits not assigned.
54	Prior payments – payers and patient	The amount the provider has received toward payment of this bill before the billing date by the indicated payer	**A:** Primary **B:** Secondary **C:** Tertiary **P** or **D:** Due from patient
55	Estimated amount due	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility, less prior payments)	
56	NPI	This field lists the National Provider Identifier number.	N/A
57	Other provider ID	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization	
58	Insured's name	The name of the individual in whose name the insurance is carried	**A:** Primary **B:** Secondary **C:** Tertiary
59	Patient's relationship to insured	A code indicating the relationship of the patient to the identified insured	

Locator field	Field description	Field definition	Code structure
60	Insured unique ID	Unique Insured ID number	N/A
61	Group name	Name of the group or plan through which the insurance is provided to the insured	**A:** Primary **B:** Secondary **C:** Tertiary
62	Insurance group number	The ID number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered	
63	Treatment authorization codes	A number or other indicator that designates that the treatment covered by this bill has been authorized from the payer	
64	Document control number	The claim number that the health plan sends back when paying or denying a claim. The number is listed on the EOB or voucher.	N/A
65	Employer name	The name of the employer that provides healthcare coverage for the insured individual identified in field **58**	**A:** Primary **B:** Secondary **C:** Tertiary
66	Diagnosis	The ICD-9-CM/ICD-10-CM diagnosis codes corresponding to all conditions that coexist at the time of the admission. The field includes conditions that develop later, affecting the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are excluded. The principal diagnosis in Locator Field **67** is not included in A-Q.	N/A
67	Principal diagnosis	The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis can be more severe than the principal diagnosis, the hospital types the principal diagnosis.	
68	Blank	N/A	N/A
69	Admit DX	The condition (ICD-9-CM/ICD-10-CM diagnosis code) identified by the physician at the time of the patient's admission requiring hospitalization	

Locator field	Field description	Field definition	Code structure
70	Patient Reason DX	The ICD-9-CM/ICD-10-CM diagnosis codes corresponding to the patient's reason for the visit to the hospital	N/A
71	Prospective Payment System (PPS) code	The Diagnosis-Related Group (DRG) Number code for an inpatient claim. The facility determines what the DRG code is based on the diagnoses and procedures reported.	
72	ECI – External Cause of Injury code (e-code)	The ICD-9-CM/ICD-10-CM code for the external cause of an injury, poisoning or adverse effect	
73	Blank	N/A	
74	Principal procedure code and date	The code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed	
74 a-e	Other procedure codes and dates	Codes that identify the other procedures performed during the period covered by the bill and the dates on which the other procedures described on the bill were performed	
75	Blank	N/A	N/A
76	Attending NPI qual/first and last	This field lists the NPI of the attending physician.	
77	Operating NPI qual/first and last	This field lists the NPI of the operating physician.	
78 – 79	Other NPI qual/ first and last	This field lists the NPI of any other treating physician.	
80	Remarks	Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements	

CMS-1500 Claim form required fields

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 QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. 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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Locator fields for the CMS-1500 claim form

Locator field	Field description	Field definition	Code structure
1	Member policy	Member's policy type	N/A
1a	Insured's ID number	Member's policy ID number	
2	Patient's name	Member's full name	
3	Date of Bbirth and sex	• Date of birth of the patient • Sex of the patient as recorded at date of service	
4	Insured's name	Policy holder's full name	
5	Patient address and telephone	Address and telephone of the patient as listed by the payer organization	
6	Patient relationship to insured	Check the appropriate option for patient relationship to the insured	
7	Insured address and telephone	Address and telephone of the insured as listed by the payer organization	
8	Reserved for NUCC use	Blank	
9	Other insured's name	Full name of the other insured policy holder	
9a	Other insured's policy or group number	Other insured policy or group number	
9b	Reserved for NUCC use	Blank	
9c	Reserved for NUCC use	Blank	
9d	Insurance plan name or program name	Name of the Insurance plan or program for other insured	
10	Is patient's related condition to:	Blank	N/A
10a	Employment? (current or previous)	Is the condition the patient is being treated for related to their employment?	
10b	Auto-accident? (place/state)	• Is the condition the patient is being treated for related to an auto accident? • In which state did the auto accident occur in?	
10c	Other accident?	Is the condition that the patient is being treated for related to any other accident?	

Locator field	Field description	Field definition	Code structure
10d	Claim codes	Codes designated by NUCC	N/A
11	Insured's policy group of FECA number	The group number of the patient's plan	
11a	Insured's date of birth/sex	The date of birth and sex of the insured	
11b	Other Claim ID	Designated by NUCC	
11c	Insurance plan name or program name	Name of the insurance plan and type of plan	
11d	Is there another health benefit plan?	Is there another health benefit plan for the insured? • If **yes**, complete fields **9, 9a** and **9d**.	Yes or No
12	Patient's or authorized person's signature	Signature for release of any medical or other information necessary to process this claim and date	N/A
13	Insured's or authorized person's signature	Signature to authorize payment of medical benefits to the undersigned physician or supplier for the following services described	
14	Date of current illness, injury or pregnancy	Date the illness, injury or pregnancy began	
15	Other date	Other date, if needed, for illness, injury or pregnancy	
16	Dates patient unable to Work in current occupation	Dates, if any, that the patient can't work	
17	Name of referring provider or other source	Name of the referring provider	
17a	Name of referring provider or other source	Additional name, if needed	
17b	NPI	NPI of the referring provider or other source	
18	Hospitalization dates related to current services	Any hospital dates related to the patient's current services	

Locator field	Field description	Field definition	Code structure
19	Additional claim information	Designated by NUCC	N/A
20	Outside lab?	Was there an outside lab used for any of the services and charges?	Yes or No
21	Diagnosis or nature of illness or injury	• A code used to identify conditions relating to the bill that can affect payer processing. An indicator of 9 or 0 is used for the ICD-10 implementation. • Codes A-L are the ICDs to be listed by the provider. The ICD indicator determines if providers are using ICD 9 or ICD 10 codes.	A. B. C. D. E. F. G. H. I. J. K. L.
22	Resubmission code	• 1-digit code to identify resubmitted/corrected claim form • Original reference number	N/A
23	Prior authorization number	Prior authorization number obtained from insurance company/vendor	
24a	Dates of service	• Dates of service/dates the patient was seen • From MM/DD/YY to MM/DD/YY	
24b	Place of service	The place of service where the treatment/visit took place	
24c	EMG	If the service provided was in response to an emergency	
24d	CPT/HCPCS and modifier	• CPT/HCPCS is a 5-digit code. • Some have 1 letter, used to identify the procedure or services performed by the rendering provider. • A modifier is a code that provides a detailed description of the services/procedures being performed.	
24e	Diagnosis pointer	A code that identifies a specific order of importance in relation to the service being performed	1. 2. 3. 4. 5. 6. 7. 8. 9.
24f	$ Charges	Charges for CPT/HCPCS identified in **24d**	N/A
24g	Days or units	The number of medical visits, procedures, units and so on	
24h	EPSDT family plan	If the service is related to family plan or Child Health and Disability Prevention screening	
24i	ID qualifier	ID qualifier when billing for emergency services	

Locator field	Field description	Field definition	Code structure
24j	Rendering provider ID number	Rendering provider ID number/NPI	N/A
25	Federal Tax ID Number (SSN/EIN)	• Federal TIN or EIN of the billing provider • Select the appropriate box	
26	Patient's account number	The patient's medical record number or account number. This number populates on the EOR.	
27	Accept assignment?	Does the billing provider accept assignment?	Yes or No
28	Total charge	The total for all the services billed in dollars and cents	N/A
29	Amount paid	• The amount of payment received from any other health insurance coverage for the payment • Medicare payments are not entered in this field.	
30	Reserved for NUCC use	Blank	N/A
31	Signature of physician or supplier including degrees or credentials and date	The claim is signed and dated by the provider or a representative assigned by the provider in black ink. Only an original signature is accepted.	
32	Service facility location information	• The provider name, address, city, state and ZIP code • The telephone number of the facility where the services were rendered	
32a	NPI	The National Provider Identifier number	
32b	NPI	Used only for an atypical service facility	
33	Billing provider information and phone number	Billing provider information and phone number of who the payment is to be made to. Provider name, address, city, state, ZIP code and telephone number.	
33a	NPI	Billing provider NPI	**A:** Primary Payer **B:** Secondary Payer **C:** Tertiary Payer
33b	Insured unique ID	Used by atypical providers for the Medicaid ID and by billing providers for their taxonomy	N/A

Code editing

The National Correct Coding Initiative (NCCI) and other applicable coding standards

Humana Healthy Horizons applies code editing rules to claims submitted for the South Carolina Medicaid plan, such as the accuracy of diagnosis and procedure codes, to ensure claims are processed consistently, accurately and efficiently. We apply these rules to better align with the American Medical Association CPT, HCPCS and ICD code sets.

Our code editing review may identify coding conflicts or inconsistent information on a claim. For example, a claim may contain a conflict between the patient's age and the procedure code, such as the submission for an adult patient of a procedure code limited to services provided to an infant. Humana Healthy Horizons' code editing software resolves these conflicts or indicates a need for additional information from the provider. Humana Healthy Horizons' code editing review evaluates the appropriateness of the procedure code only, not the medical necessity of the procedure. Humana Healthy Horizons provides notification of upcoming code editing changes.

The following additional resources are provided to assist you with coding issues. More information on claims code editing rules can be found by visiting the links below:

- **NCCI for Medicaid | CMS**
- **Humana Healthy Horizons in South Carolina Claims Code Editing Rules**
- **Code Edit General Reminders and Special Announcements from Humana**
- **Claims Coding, Inquiry Process Guidelines - Humana**
- Code Edit Stimulator on **Availity Essentials**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program developed for Medicaid recipients providing comprehensive and preventive healthcare services from birth through the month of their 21st year. All Humana Healthy Horizons members within this age range should receive age recommended EPSDT preventive exams, health screens and EPSDT special services needed to address health issues as soon as identified or suspected. EPSDT benefits are available at no cost to members.

Covered services include:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Laboratory tests, including (where indicated) blood/lead level screening/testing, anemia test using hematocrit or hemoglobin determinations, sickle cell test, complete urinalysis, testing for sexually transmitted diseases, tuberculin test and pelvic examination

- Developmental screening/surveillance, including autism screening
- Sensory screenings and referrals for vision and hearing
- Nutritional assessment, including body mass index and blood pressure
- Dental screenings and referrals to a dentist, as indicated (dental referrals are recommended to begin during a child's first year of life and are required at 2 years and older)
- Psychological/behavioral assessments, substance-use assessments and depression screenings
- Assessment of immunization status and administration of required vaccines
- Health education and anticipatory guidance (e.g., age-appropriate development, healthy lifestyles, accident and disease prevention, at-risk and risk behaviors, and safety)
- Referral for further evaluation, diagnosis and treatment
- Routine screening for postpartum depression should be integrated into well-child visits at 1, 2, 5 and 6 months

EPSDT claims are submitted on a CMS-1500 form using CPT procedure codes. More details are available at **EPSDT**.

Immunization guidance

Recommended vaccinations for infants and children from birth through 6 years, as well as ages 7 to 18 years, can be found at **Vaccine Schedule for Children 6 Years or Younger | CDC**.

Oral health and dental services

Routine and emergency dental services are available to members younger than 21. Limited dental services are available to members ages 21 and older. Call DentaQuest at **888-307-6552** or visit **Dentaquest.com**.

Following the recommendations of the American Academy of Pediatric Dentistry, SCDHHS has developed a **Dental Periodicity Schedule | EPSDT (scdhhs.gov)**.

Outpatient dental and oral health services

Preventive, diagnostic, therapeutic, rehabilitative, surgical, mental health, facility services for dental, and emergency services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours can be covered. Additional details on dental services are available at **Outpatient Dental and Oral Health Services**.

Value-added benefits

Humana Healthy Horizons members receive added benefits along with medical coverage. These extra benefits, tools and services are available at no cost to the member.

A full list of value added benefits can be found at **South Carolina Medicaid Benefits: Value-Added Services - Humana.**

Billing Guidance for Value-Added Benefits

To ensure proper payment for Value-Added Benefits, please utilize the table below:

Benefit category	Code/modifier	Age limit	Detail of committed benefit
Durable medical equipment: Breast pumps	E0603, E0604	All	Female members can receive 1 non-hospital grade breast pump every 2 years, 1 rental of a hospital grade breast pump if the baby requires an inpatient stay in a neonatal intensive care unit (NICU)
Newborn circumcision	54150, 54160, 54161	29 days – 12 months	N/A
Sports physicals	99382 – 99385, 99392 – 99395, 99201 – 99215	6 – 18 years	Must bill diagnosis code Z02.5

Coverage and billing assistance for Centering Pregnancy Group Prenatal Care

Centering Pregnancy is a model of prenatal care provided in a group setting that gives patients more time with their provider and encourages interaction with other expectant mothers. Through this service, participants meet to discuss maternal and infant health as a group while receiving clinical supervision and support. To qualify for the benefit, a Medicaid member must be a female between 12 and 55 years of age.

Billing and reimbursement

The Centering Healthcare Institute certifies providers offering Centering Pregnancy programs. To qualify for reimbursement for Centering Pregnancy group clinical visits, a provider must be a site approved by the Centering Healthcare Institute or be under the Centering grant contract through SCDHHS in preparation for formal site approval, and the provider must provide group prenatal care using the Centering Pregnancy model.

Group clinical visits must last at least 1.5 hours, with a minimum of 2 clients and a maximum of 20 clients. Following the recommended Centering Pregnancy model, up to 10 group clinical visits prior to delivery may be covered. Providers must use educational materials from the Centering Pregnancy curriculum, and these must be incorporated into the educational portion of the group clinical visit.

Providers must submit a claim for a group clinical visit for the management of pregnancy using procedure code 99078 and modifier TH. The claim must include a pregnancy diagnosis code (ICD-10 series Z34- for normal pregnancy, and ICD-10 series O09- for high-risk pregnancy).

For claims with procedure code 99078 with modifier TH to be eligible for reimbursement, they must be submitted for the same date of service as claims by the same provider for an established patient visit (E/M procedure codes 99211, 99212, 99213, 99214 or 99215) with modifier TH.

The Centering Healthcare Institute lists sites in South Carolina currently approved to provide Centering Pregnancy services on its webpage. For more information, please visit **Centering Sites in South Carolina**.

If you have any questions regarding this policy, please call the SCDHHS's Provider Service Center at **888-289-0709**. Thank you for your continued support of the South Carolina Healthy Connections Medicaid program.

Screening, brief intervention, and referral to treatment

Screening, brief intervention and referral to treatment (SBIRT) is an evidence-based practice used to identify, reduce and prevent problematic use of and dependence on alcohol and recreational drugs. The goal is to improve the identification of clinical care and coordination for perinatal women using substances.

SBIRT screening services can be billed with service code H0002 along with the appropriate modifier based on the provider type. Additional information can be found at **Updated RBHS Fee Schedule.pdf (scdhhs.gov)**.

Federally Qualified Health Centers and Rural Health Clinics

Unless you're a contracted or in-network provider, in which case claims billing and reimbursement will follow the terms and conditions of your contract, FQHC and RHC providers should follow the state's guidelines. Additional information can be found at **Search | SC DHHS**.

Frequent contact numbers and addresses can be found in the **Humana Healthy Horizons in South Carolina Provider Resource Guide**.