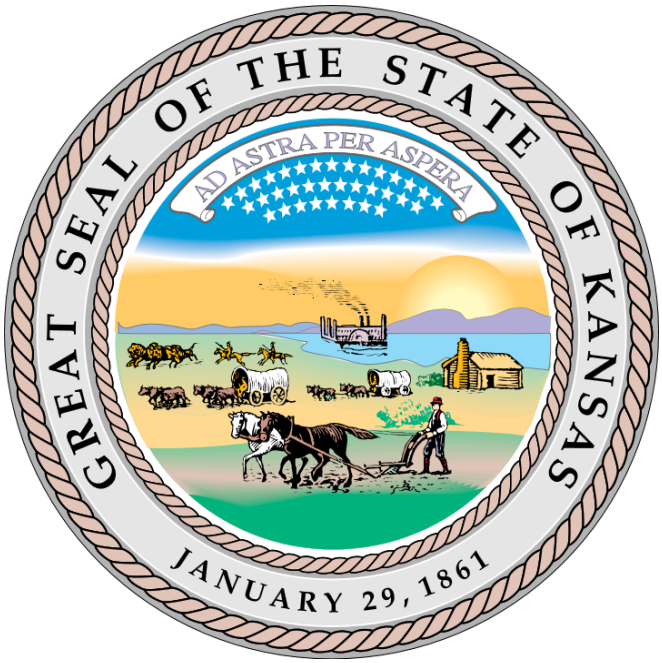


# *Kansas Local Health Department Clinical Services Coding Resource Guide*

## *Updated: February 2019*

Disclaimer: This manual has been a collaborative effort from numerous health department billers across the state. The information contained is provided only as a suggestion of possible use. Many policies, procedures and codes will vary based on individual departments, services offered, and individual situations. **It is the responsibility of every department to verify information as it pertains to their own individual departments prior to using this information.**

Kansas Department of Health and Environment

KALHD Kansas Association of Local Health Departments

WSU Wichita State University Community Engagement Institute

Center for Public Health Initiatives

# PREFACE

The **Public Health Billing Resource Manual** provides policy & procedural guidance on how to bill 3rd party payers for public health programs and services. Developed as a billing resource tool; its purpose is to assist state, district and county public health staff in understanding the insurance coding and billing process.

**Part I-The Policies and Procedures** section focuses on the terms and conditions of billing and reimbursement from 3rd party payers. It provides guidance on eligibility & verification, coordination of benefits and billing procedures to avoid delays in reimbursement.

**Part II-The Billing & Coding: Methodologies & Rates** section emphasizes the importance of the clinical components of CPT coding to ensure 3rd party payers are charged at the appropriate level of service delivery and reimbursement.

The **Appendices** section includes Related Links, Billing Contact Information, Acronyms, Definitions, and other resources used in mastering the reimbursement process.

Amendments are made Semi-annually in accordance with policy changes in federal and state laws.

**Disclaimer:** Contract Provisions between LHD and 3rd Party Private Payers contain confidential and proprietary information that prohibits dissemination, distribution or disclosure of reimbursement rates to any parties other than county Boards of Health and LHD employees.

Currently, KanCare is contracted with the following 3rd Party Payers for Immunization Services:
*Sunflower State Health Plan*
*Aetna Health Plan*
*United Healthcare Community Plan*

Note: MediKan and Medicare are accepted for other services, i.e., Maternal and Child Health, Family Planning, Adult Health, etc. in most of our county health departments.

*Special thanks* to all of the billers who worked on this manual and those who will contribute to future updates. This work would not have happened without you.

**Any comments or suggestions for updates and changes to this manual can be emailed to the billers listed in section 11.6 or aaron.davis@wichita.edu.**

# Updates from June 2017 Version

| Section | Update Notes |
|---|---|
| Cover | Date/version updated |
| 3.2 Primary & Secondary Payers | General updates |
| 4.3 Filing Time Limits | Updates to known timeframes and Aetna added |
| 4.6 Claim Submission & Resubmission | MCO Reconsideration Process updates |
| 5.1 Website Introduction | Additional guidance on browser use added |
| 6.1 Immunization Services | Updates to language for VFP TPL |
| 6.3 Immunizations 18 years of age and younger | Updates to tables; specifically for HPV and Shingrix |
| 6.6 Medicare Part D | Updates to tables; specifically for Shingrix |
| 6.7 Influenza Vaccine Products | Updated products and codes for 2018-2019 season |
| 7.1 Child Health Services | Updates made to reflect changes in EP modifier bundling going away as of November 1, 2018 |
| 8.1 Women's Health Services: Methodologies | Updates to guidance on use of Modifier 25 |
| 8.2 Family Planning | Updates for codes and guidance on Smoking Cessation Group Class; Makena added as a contraceptive product |
| 10.1 Laboratory Service | Updates to 'suggested' Blood lead ICD-10s |
| Section 11 Appendices | Section has been renumbered. New appendices have been added and updated<br>• 11.3 Related Links – broken links have been updated<br>• 11.5 Definitions have been added/adjusted<br>• 11.6 KALHD Billing List Serve & Regional Billing Groups map – contact information has been updated<br>• 11.7 Map updates<br>• 11.12 KanBe-Helathy Billing Reference added |

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# PART II METHODOLOGIES & COMMON LHD CODING

# PART I

# BILLING POLICIES & PROCEDURES

# Section 1

# Provider Enrollment

## 1.1 Introduction

Providers must be enrolled as a qualified provider with a 3rd party payer before they can submit claims for reimbursement. This section provides guidance on the Enrollment Process.

## 1.2 Medicaid Enrollment Process

A Kansas Medical Assistance Program (KMAP) Provider Agreement must be completed in order to participate in the Kansas Medical Assistance Program (https://www.kmap-state-ks.us/Public/homepage.asp).

The State has selected three health plans, or managed care organizations (MCOs), to provide services to Medicaid consumers in the KanCare program. More information about each plan and how to contact them can be found at http://www.kancare.ks.gov/providers/health-plan-information. Departments must enter into contracts with each MCO individually. KMAP enrollment is required before enrolling with a Medicaid MCO.

## 1.3 Private Insurance Enrollment Process

In order to bill most payers, the LHD must be contracted with the payer. It is best to contact each payer and ask how claims will be processed with and without a contract. Also an LHD may contract with a network. This allows the LHD to bill multiple payers under one contract. These are links in the PDF version of this manual.

| Payer | Private Insurances | Phone number | Website |
|---|---|---|---|
| BCBS | BCBS | 800-432-3587 | http://bcbsks.com/CustomerService/Providers/ |
| Aetna | Aetna<br>Coventry Health Care KS<br>Preferred Health | 800-624-0756 | https://www.aetna.com/health-care-professionals.html |
| HPK | Network of insurances | 316-652-1327 | http://hpkansas.com/forms/ |
| ProviDr's | ProviDr's Care (WPPA) | 800-801-9772 | http://providrscare.net/providers/ |
| WPS | WPS – Medicare B | 866-518-3285 | https://www.wpsgha.com |
| Palmetto GBA | Railroad Medicare | 866-899-5227 | http://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/Railroad%20Medicare |

# Section 2

# Insurance Eligibility & Verification

## 2.1 Introduction

The business of Public Health begins with clients seeking services at local county health departments. This Section provides guidance on client intake and the steps required to obtain insurance information for billable services rendered in public health.

## 2.2 Eligibility & Verification

Frontline staff should brief clients on the intake process prior to receiving services. An effective intake process begins with a registration form that gathers vital information on the client's demographics, insurance coverage, and services requested. *New Patients* should complete a form at their first visit. Departments should set a policy to have *Established Patients* complete one at every visit or if they have any changes in their information since their last visit. Verifying and updating this information is critical at every visit.

Important Steps that should be taken with every client at every visit:

- Copy the client's primary and any secondary insurance cards
- Verify eligibility, policy status, effective date, type of plan and **Exclusions**
- Inform client of their responsibility for co-pays, coinsurances and deductibles
- Inform client of **Waiver** for non-covered services and payment options

It is to the benefit of the Provider to verify coverage **before** services are rendered. Failure to do so may result in non-payment of non-covered services and difficulties recouping payment from the client after services have been provided. "Active" coverage does not guarantee reimbursement for services listed on the Fee Schedule. Please refer to the client's individual Insurance Plan/Exclusions to identify "Non-Covered" services.

In order to charge clients for non-covered services, a **Waiver for Non-Covered Services** with the following information must be provided to the client:

- Identify the service that is not covered
- Identify covered service that may be available in lieu of the non-covered service
- The cost of the service and payment arrangements
- The client must sign the Waiver indicating acceptance of the non-covered service and agreement to pay for the non-covered service

Medicaid/KanCare eligibility can be verified at https://www.kmap-state-ks.us

**Provider Discretion:** It is a Provider's discretion to accept a Medicaid/KanCare member as a client.

By accepting a Medicaid/KanCare member as a client, the Provider

1 Agrees to accept, as payment in full, the amount paid by Medicaid/KanCare for all covered services with the exception of co-pays and payments from 3rd party payers.
2 Is prohibited from choosing specific procedures for which the Provider will accept Medicaid/KanCare, whereby the Medicaid client would be required to pay for one type of covered service and Medicaid to pay for another service if applicable.

Failure to comply with these procedures will subject the Provider to sanctions, up to and including termination from the Medicaid/KanCare Program.

*Some Departments will use procedures such as:*
When a client is ready to check-out, the paystation collects any copayments, deductibles, and service fees. Payment in full is expected at time of service. If a client is unable to pay, the clinical manager may make payment arrangements. The clinic manager should reinforce the Board of Health's or Health Department's billing policy and resolve the issue with the client through an agreed payment plan.

# Section 3

# Coordination of Benefits

## 3.1 Introduction

By federal law, Medicaid is the "payer of last resort" in most circumstances. Coordination of Benefits (COB) is the process of determining the primary payer. This section will help define the "payer of last resort" status when submitting claims for payment. To find out more information on COB please refer to General TPL Payment Manual on the KMAP website.

## 3.2 Primary & Secondary Payers

Third-party liability (TPL) is often referred to as other insurance (OI), other health insurance (OHI), or other insurance coverage (OIC). Other insurance is considered a third-party resource for the beneficiary. Third-party resources can be health insurance (including Medicare), casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more beneficiaries.

The Kansas Medical Assistance Program (KMAP) is a secondary payer to all other insurance programs (including Medicare) and should be billed only after payment or denial has been received from such carriers. The only exceptions to this policy are listed below:

- Children and Youth with Special Health Care Needs (CYSHCN) program
- Kansas Department for Children and Families (DCF), formerly SRS
- Indian Health Services (IHS)
- Crime Victim's Compensation
- Vaccine for Children Program

## 3.3 Third Party Liability Payment

**Details for TPL billing can be found at** https://www.kmap-state-ks.us/Public/providermanuals.asp under General TPL Payment Manual.

- The Provider's Role
- Billing Requirements
- Other Insurance Pricing
- Billing TPL after Receipt of KMAP Payment
- TPL Payment after Medicaid Payment
- No Response from Other Insurance
- Documentation Requirements
- Blanket Denials and Noncovered Codes

The following tips will assist Providers in reducing payment delays attributed to COB- related problems:

1. Ask All Patients about Secondary Insurance Coverage. Collect and confirm primary and secondary insurance information at each visit.

2. Know What Plans and Payers Need to Pay Claims. Nearly all plans require a copy of the Explanation of Benefits (EOB) from the primary payer prior to paying a claim as the secondary payer. Most plans and payers publish their requirements and the information should be available in provider manuals, online, and by contacting physician/provider representatives.

3. Primary & Secondary Payers: The following rules are used to determine the primary and secondary payer: a) The payer covering the patient as a subscriber will be the primary payer. b) If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the Birthday Rule.

| **WHAT IF…the Medicaid Member is also eligible for Medicare?** | | |
|---|---|---|
| **SERVICE BY MEDICAID PROGRAM** | **MEDICARE** | **MEDICAID** |
| Health Check/Immunization | Does not Cover | Primary Payer |
| Family Planning | Does not Cover | Primary Payer |
| Perinatal Case Management/Pregnancy Related Services | Does not Cover | Primary Payer |
| Dental Services (Health Check, Adult) | Does not Cover | Primary Payer |
| Adult Services/Immunizations | Primary Payer-Flu, Pneumonia, Hep B; MNT; Preventive Services | Secondary Payer |
| Nurse Practitioner/Physician Services | Primary Payer | Secondary Payer |

| **WHAT IF…the Medicaid Member is also eligible for other private insurance** | | |
|---|---|---|
| **SERVICE BY MEDICAID PROGRAM** | **PRIVATE INSURANCE** | **MEDICAID** |
| Health Check/Immunizations | N/A | Primary Payer |
| Perinatal Case Management/Pregnancy Related | N/A | Primary Payer |
| Family Planning | COB REQUIRED | |
| Adult Services/Immunizations | COB REQUIRED | |
| Nurse Practitioner/Physician Services | COB REQUIRED | |
| Dental Services (Health Check, Adult) | COB REQUIRED | |

## 3.4 Third Party Liability Noncovered List (Blanket Denial)

When a service is not covered by a beneficiary's primary insurance plan, a blanket denial letter can be requested from the insurance carrier. The insurance carrier should then issue, on company letterhead, a document stating the service is not covered by the insurance plan covering the Medicaid beneficiary. The provider can also use a benefits booklet from the other insurance if it shows that the service is not covered. Providers can retain this statement on file to be used as proof of denial for one year. The noncovered status must be reconfirmed and a new letter obtained at the end of one year.

The most up-to-date TPL Noncovered List is located on KMAP and can be accessed here: https://www.kmap-state-ks.us/Public/TPL%20Noncovered.asp

# Section 4

# Claim Submission / Resubmission

## 4.1 Introduction

The Submission & Resubmission of Claims focuses on the importance of converting clinical services provided to a client into billable claims and submitting them via an Electronic Data Interchange to 3rd party payers for reimbursement. To receive proper payment for services, public health billing staff must collect accurate information required to submit a CMS 1500 insurance form correctly.

## 4.2 Claim Requirements

Providers must take all reasonable measures to determine a 3rd Party Payer's liability for covered services prior to filing a Medicaid claim. If a 3rd party insurance plan denies or pays insufficiently the applicable reimbursement rate:

- Attach proof of other insurance denial (an RA or letter of EOB from the insurer). Denials requesting additional information from the primary insurance company will not be accepted as proof of denial from the other insurance. If dates of service are over 12 months old, original timely filing must be proven as defined in Section 5100 of the General Billing Fee-for-Service Provider Manual. An original denial is only acceptable for the same service date(s) on the claim.
- When a Medicare supplemental plan (for example Plan 65) is the only other insurance applicable to the beneficiary and Medicare has denied payment on the claim, the provider is not required to submit the claim to the Medicare supplemental for denial. In this instance, the provider should resolve all denials through Medicare prior to billing the Medicare supplemental plan and Medicaid.
- When a carrier issues a blanket denial letter for a noncovered procedure code, the provider should include a copy of the denial and notate CARC code PR192 on the attachment. Refer to the Blanket Denials and Noncovered Codes portion of Section 3100 for documentation requirements (see section 3.3 of this manual).

For MCOs, failure to file a claim within the contracted timely filing after a service is rendered and/or failure to obtain a required prior approval or precertification will result in a denial of that claim. Obtaining prior approval or precertification does not guarantee payment of a claim.

If a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a claim.

A 3rd Party Payer may deny part or all of a claim for the following reasons: 1) The services are not covered; 2) The client was not eligible on the date of service; 3) The provider failed to obtain prior approval or precertification for the required services; or, 4) The services provided have been determined to be medically unnecessary.

Federal law prohibits State payments for Medicaid services to anyone other than a provider, except in specified circumstances. Expressly prohibited are payments to collection agencies working on a percentage or other basis unrelated to the cost of processing the billing.

## 4.3 Filing Time Limits

Every health insurance company has its own policy on timely filing. Visit each payer site or contact a representative for details and updated information.

| | |
|---|---|
| **Aetna** | Submission: dependent on contract agreement<br>Appeals/Payment Disputes: contract specific |
| **Sunflower State** | Submission: dependent on contract agreement. When Sunflower State is the secondary payer, claims must be received within 365 calendar days from date of the final determination of the primary payer.<br>Resubmission: 180 calendar days from the original date of notification of payment or denial<br>Appeals/Payment Disputes: 180 calendar days from the original date of notification of payment or denial |
| **United Healthcare Community Plan** | Submission of claims: dependent on contract agreement.<br>Appeals/Payment Disputes: 30 calendar days of the adjudication date of the EOB. |
| **Medicaid** | Submission: 12 months after the date of service.<br>Appeals/Payment Disputes: 24 months after the date of service. |
| **Medicare** | Submission: Claims must be received within 1 calendar year from the date of service.<br>Appeals/Reconsiderations: Must be submitted within 6 months of the date on the notice of redetermination letter. |
| **BCBS** | Submission: 15 months from date of service.<br>Appeals/Payment Disputes: 120 days from the date of the RA for retrospective review; 60 days from the date of the retrospective review determination for appeals. |
| **AETNA/COVENTRY** | Submission: 120 days from date of service.<br>Resubmission: 180 days from date of denial/processing<br>Appeals/Payment Disputes: 180 days of the initial claim decision for reconsiderations; 60 days of previous decision for appeals |

## 4.4 Appeals Process

Every health insurance company has a grievance and appeal procedure defined in its policy. You can appeal a 3rd party payer's decision to deny a claim or pay less than the amount billed. Please refer to the appropriate payer's website for instructions on to appeal a claim.

The 3rd party payer may still deny a claim based on medical necessity despite pre-approval and a correctly coded claim. Appeal requests that do not contain sufficient information will not be processed.

## 4.5 Medicaid Denial Issues

When facing denials, there are multiple reasons that could be causing the issue. The first step in dealing with a denial is to review the denial code and determine what is causing the denial. Review prior claims or reach out for assistance from other billers. If you are still unsure of a correct course of action review the following website: http://www.kancare.ks.gov/docs/default-source/providers/faqs/provider-contacts.pdf. This site contains a contact for KDHE. KDHE should be contacted only when all other resources have been exhausted.

## 4.6 MCO Reconsideration Process

KMAP General Bulletin 17105

Effective May 1, 2017, KanCare providers will have the opportunity to dispute a denial of payment, in whole or in part, by a KanCare managed care organization (MCO) by submitting a Reconsideration and/or an Appeal to the MCO. Submission of a Reconsideration request is optional. The Reconsideration process offers providers an opportunity to submit a request to the MCOs to review a denial of payment prior to requesting an Appeal.

The Reconsideration process does not replace the Appeal process. Providers have the opportunity to submit an Appeal request to the MCO instead of submitting a Reconsideration request or after receipt of the Reconsideration resolution notice. A Reconsideration request must be submitted to the MCO no later than 120 calendar days from the date of the denial notice or Explanation of Payment (EOP). Once an MCO receives the Reconsideration request, it will review the payment denial and issue a Reconsideration resolution notice. A response to a reconsideration may not come in the form of a letter, it may come on a Remittance Advice. An Appeal request must be submitted to the MCO no later than 60 calendar days from the date of the denial notice or EOP or no later than 60 calendar days from the date of the Reconsideration resolution notice.

Completion of the Reconsideration process is not required prior to requesting an Appeal. Providers may terminate the Reconsideration process and file an Appeal within 60 calendar days of the date of the denial notice. Providers must complete the MCO's Appeal process prior to requesting a State Fair Hearing. Currently the MCOs have different processes for submitting a claim reconsideration. Refer to payer website for instructions.

# Section 5

# KMAP: Kansas Medical Assistance Program

## 5.1 Website Introduction

The Kansas Medical Assistance Program (KMAP) website provides users with access to a variety of information such as eligibility verification, claim submission and inquiry, and prior authorizations. Visit https://www.kmap-state-ks.us/public/homepage.asp for more information on enrollment. (Not all browsers are compatible with the KMAP website, and most of the current versions cause the site to be difficult to use. Try switching browsers or using an older version if the information is not displayed correctly. The website works best using internet explorer and adding the site to "compatability view" under the tools menu.)

After logging in to the website, the mailbox view opens. Any recent changes will be listed here. These are official notifications and become part of your provider agreement. Any questions on KMAP specifics or issues in submitting claims can be discussed with a KMAP representative at 1-800-933-6593.

For those unfamiliar with submitting claims through KMAP, the Professional Billing Packet is the best place to start. The most current version can be found here: https://www.kmap-state-ks.us/Public/Workshop%20Schedule/Workshop%20Materials.asp

Below is an outline of the more frequently used resources available. These are links in the PDF version of this manual.

## 5.2 Eligibility Verification and Prior Authorizations

- Eligibility Verification
- Prior Authorizations
  - Submit Prior Authorization Request
  - Prior Authorization Inquiry
  - Submit Service Referral
  - Service Referral Search

## 5.3 KanCare Claim Submission & Inquiry

- Claim Submission
  - Dental
  - Institutional (Inpatient, Outpatient, Long Term Care and Medicare Cross-over)
  - Professional
  - Pharmacy
  - Right to Appeal
- Claim Inquiry

## 5.4 Manuals, Forms and Bulletins

- Provider Manuals
- Forms
- Bulletins

## 5.5 Interactive Tools - KMAP Reference Codes

Pricing & Limitation information for Procedures, Diagnosis, Drugs, and Revenue Codes

- KMAP Reference Codes
  - Search by Procedure
  - Search by NDC
  - Search by Diagnosis
  - Coding Modifiers Table
  - Download Fee Schedules
  - MS-DRG (Medicare Severity Diagnosis-Related Group) to CMS-DRG Crosswalk
  - HCPCS Reference List
  - Pharmacy Federal and State Pricing
  - Fee Schedule for Outpatient Hospitals
- HCPCS Code Search
- Provider Services Profile: listing of the recent services a beneficiary has received
- EOB Crosswalks

## 5.6 KMAP Fee-for Service Provider Manual: General Benefits

When looking for Medicaid benefit details, the most current version of the "General Benefits" manual should be consulted. This is located in the *Provider Manual* link noted above, with a selection of "General Benefits." Below is an example of a key components of the 7/6/16 Manual that is regularly questioned.

**2700. DOCUMENTATION REQUIREMENTS** Updated 10/15

**Claim/Record Storage Requirements**

K.S.A. 21-5931 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. (This requirement includes primary care case management and lock-in referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.

Providers who submit claims through computerized systems must maintain these records in a manner which is retrievable.

If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers:

- To keep such records as necessary to disclose fully the extent of services rendered to beneficiaries
- To furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider

Providing medical records to KDHE-DHCF or its designee is not a billable charge.

# PART II

# METHODOLOGIES & COMMON LHD CODING

# Section 6

# Immunization Services

## 6.1 Methodologies

The following guidance will allow for successful billing and maximum reimbursement of Immunization Services.

- Information on the Vaccine for Children Program - Eligibility Criteria for vaccines can be found @ http://www.cdc.gov/vaccines/programs/vfc/providers/eligibility.html
- KIP_Private_VFC_CHIP_Vaccine_Flow_Chart billing guidance can be found @ http://www.kdheks.gov/immunize/download/KIP_Private_VFC_CHIP_Vaccine_Flow_Chart.pdf
- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered. Reimbursements of CPT® codes for vaccines covered under the Vaccine for Children (VFC) program will not be allowed.
- **Some software requires a charge on each line item being submitted.** Known systems are KIPHS, and UHC Community. Providers need to indicate a charge, usually either $.01 or $1.00, on the line for the vaccine/toxoid code. Some LHD's bill the vaccine codes with the monetary amount to all three MCOs to maintain consistency. The system should deny the service even though a charge was submitted, although periodically the MCO's will inadvertintly pay the vaccine code.
- As of October 29, 2010, administration of Vaccine for Children vaccines is exempt from third-party liability (TPL). When they are billed with an appropriate administrative code, providers do not have to bill the claim to the TPL carrier before Medicaid will process the claim for payment.
- **Modifier 25** should be attached to the E/M service code if vaccines are administered during the same visit.

## 6.2 Vaccine guidance for dual coverage

***If a CHIP (T21) child has both private insurance and T21 what vaccine do you use?***

Use private vaccine and bill the insurance company for the vaccine and administration fee. If CHIP vaccine is used by mistake, bill the private insurance company for the vaccine administration charge only. It is best to determine the child's coverage for immunizations before the service is provided this way you can use the correct vaccine funding source. If the child's private insurance does not cover vaccine, the child is CHIP eligible and CHIP vaccine is used. Be sure to keep this documentation in the child permanent record. This is important to avoid denials of claims and to help your clinic and the CHIP program to be sure the correct payer is billed for immunization services. If you receive a denial from the private insurer and you determined the child had immunization coverage, please contact CHIP customer service 1-800-766-9012 for assistance.

*This explanation was published in the FAQ document from KIP updated 3/4/14.*

***If a child has private insurance and T19 is secondary what vaccine funding source do I use and who is billed?*** Resource is from the 2015 CDC VFC Program Operation Guide page 29.

*INSURED EXCEPTIONS*

AI/AN with Health Insurance that Covers Immunizations:
AI/AN children are always VFC-eligible. VFC is an entitlement program and participation is not mandatory for an eligible child. For AI/AN children that have full immunization benefits through a primary private insurer, the decision to participate in the VFC program should be made based on what is most cost beneficial to the child and family.

Insured and Medicaid as Secondary Insurance:
Situations occur where children may have private health insurance and Medicaid (T19) as secondary insurance. These children will be VFC-eligible as long as they are enrolled in Medicaid (T19). However, the parent is not required to participate in the VFC program. There are options for the parent and provider. These options are described below:

***Option 1***
A provider can administer VFC vaccine to these children and bill the Medicaid agency for the administration fee. In most healthcare situations, Medicaid is considered the "payer of last resort." This means that claims must be filed to and rejected by all other insurers before the Medicaid agency will consider payment for the service. This is not true of the VFC vaccine administration fee for Medicaid-eligible children. The Medicaid program must pay the VFC administration fee because immunizations are a component of the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. However, once the claim is submitted to Medicaid, the state Medicaid agency does have the option to seek reimbursement for the administration fee from the primary insurer.

Please note: If the state Medicaid agency rejects a claim for a vaccine administration fee for a child with Medicaid as secondary insurance, stating the claim must first be submitted to the primary insurer for payment, the provider should notify the awardee (KIP). The awardee (KIP) should notify their CDC project officer so that CDC can work with CMS to educate the state Medicaid agency and correct the situation.

Considerations regarding this option:
•This is the easiest way for a provider to use VFC vaccine and bill Medicaid for the administration fee.
•There are no out-of-pocket costs to the parent or guardian for the vaccine or the administration fee.

***Option 2***
A provider can administer private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee. If the primary insurer pays less than the Medicaid amount for the vaccine administration fee, the provider can bill Medicaid for the balance of the vaccine administration fee, up to the amount Medicaid pays for the administration fee. If the primary insurer denies payment of vaccine and the administration fee, the provider may replace the privately purchased vaccine with VFC vaccine and bill Medicaid for the administration fee. The provider must document this replacement on the VFC borrowing form (see Module 4).

Considerations regarding this option:
•The provider may be reimbursed a higher amount if privately purchased vaccine is administered and both the vaccine and the administration fee are billed to the primary insurer.
•The provider should choose from the vaccine inventory that is most cost-effective for the family.
•The parent/guardian of a child with Medicaid as secondary insurance should never be billed for a vaccine or an administration fee.

## 6.3 Immunizations 18 years of age and younger

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| ***Vaccine Administration*** | | | |
| Imm admin, *with counseling*; 1st or only component | 90460 | Z23 | 0 -18 yrs |
| Imm admin, *with counseling*; ea additional component<br>+ add on code* (***not Payable through KanCare)*** | 90461 | Z23 | 0 -18 yrs |
| Immunization admin; 1 vaccine | 90471 | Z23 | |
| Immunization admin; each additional vaccine<br>+ add on code* | 90472 | Z23 | |
| Immunization admin, oral, nasal; 1 vaccine | 90473 | Z23 | |
| Immunization admin, oral, nasal; each additional vaccine<br>+ add on code* | 90474 | Z23 | |
| ***Vaccines – Private and VFC*** | | | |
| DTaP, Diphtheria, Tetanus, Pertussis (Daptacel, Tripedia) | 90700 | Z23 | 0 – 6yrs |
| DTaP-Hep B-IPV (Pediarix) | 90723 | Z23 | |
| DTaP-HIB-IPV (Pentacel) | 90698 | Z23 | |
| DTaP-IPV (Kinrix) | 90696 | Z23 | 4 yrs – 6 yrs |
| Hep A, 2-dose, (Havrix,Vaqta) | 90633 | Z23 | 1yr – 18 yrs |
| Hep A, 3-dose, (Havrix) | 90634 | Z23 | 1yr – 18 yrs |
| Hep B, 3-dose (Engerix-B) | 90744 | Z23 | |
| Hep B-HIB (Comvax) | 90748 | Z23 | |
| Hep A-Hep B, (Twinrix) | 90636 | Z23 | 18 yrs |
| HIB, Hemophilus b, 3-dose (PedvaxHib) | 90647 | Z23 | |
| HIB, Hemophilus b, 4-dose, (Acthib,Hiberix) | 90648 | Z23 | |
| HPV, Human Papilloma Virus, 3-dose (Gardasil) (not a Medicaid covered cose | 90649 | Z23 | 9 yrs – 18 yrs |
| HPV, types 6, 11, 16, 18, 31, 33, 45, 52, 58 (Gardasil) | 90651 | Z23 | |
| IPV, Polio (IPOL) | 90713 | Z23 | |
| Meningococcal conjugate (Menactra, Menveo) | 90734 | Z23 | |
| MMR, Measles, Mumps, Rubella | 90707 | Z23 | |
| MMRV, Measles, Mumps, Rubella, Varicella (ProQuad) | 90710 | Z23 | |
| Pneumococcal, 7 valent (Prevnar) | 90669 | Z23 | |
| Pneumococcal, 13 valent (Prevnar 13) | 90670 | Z23 | |
| Pneumococcal, 23 valent (Pneumovax 23) | 90732 | Z23 | 2 yrs & 18 yrs |
| Rotavirus, 2-dose, live, oral (Rotarix) | 90681 | Z23 | |
| Rotavirus, 3-dose, live, oral (RotaTeq) | 90680 | Z23 | |
| Td, Tetanus, Diphtheria toxoid, preservative free (Tenivac) | 90714 | Z23 | 7 yrs & 18 yrs |
| Tdap, Tetanus, Diphtheria & Pertussis (Boostrix, Adacel) | 90715 | Z23 | 7 yrs & 18 yrs |
| Varicella, live (Varivax) | 90716 | Z23 | |

*+ add on codes: codes that are always performed in addition to the primary service or procedure & must *Never* be reported as a stand-alone-code.

## 6.4 Immunizations 19 *years of age & older*

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| ***Vaccine Administration*** | | | |
| Immunization admin; 1 vaccine | 90471 | Z23 | |
| Immunization admin; each additional vaccine<br>+ add on code* | 90472 | Z23 | |
| Immunization admin, oral, nasal; 1 vaccine | 90473 | Z23 | |
| Immunization admin, oral, nasal; each additional vaccine<br>+ add on code* | 90474 | Z23 | |
| ***Vaccines*** | | | |
| DT, Diphtheria, Tetanus toxoid | 90702 | Z23 | |
| Hep A 2-dose (Vaqta, Havrix) | 90632 | Z23 | |
| Hep A-Hep B, adult (Twinrix) | 90636 | Z23 | |
| Hep B (Recombivax) Pediatric/adolescent dose | 90744 | Z23 | 19 years only |
| Hep B (Engerix-B) | 90746 | Z23 | |
| Hep B, dialysis or Immunosuppressed | 90740 | Z23 | |
| HPV, Human Papilloma Virus, 3-dose (Gardasil)(not a Medicaid covered code) | 90649 | Z23 | |
| HPV, types 6, 11, 16, 18, 31, 33, 45, 52, 58 (Gardasil) | 90651 | Z23 | |
| IPV, Polio (IPOL) | 90713 | Z23 | |
| Meningococcal conjugate (Menactra, Menveo) | 90734 | Z23 | |
| Meningococcal polysaccharide (Menomune) (not covered by Medicaid) | 90733 | Z23 | |
| MMR, Measles, Mumps, Rubella | 90707 | Z23 | |
| MMRV, Measles, Mumps, Rubella, Varicella (ProQuad) | 90710 | Z23 | |
| Pneumococcal, 7 valent (Prevnar) | 90669 | Z23 | |
| Pneumococcal, 13 Valent (Prevnar 13) | 90670 | Z23 | |
| Pneumococcal 23-Valent (Pneumovax 23) | 90732 | Z23 | |
| Shingrix | 90750 | Z23 | 50 years & older |
| Td, Tetanus, Diphtheria toxoid, preservative free (Tenivac) | 90714 | Z23 | |
| Tdap, Tetanus, Diphtheria & Pertussis (Boostrix, Adacel) | 90715 | Z23 | |
| Varicella, live (Varivax) | 90716 | Z23 | |

*+ add on codes: codes that are always performed in addition to the primary service or procedure & must *Never* be reported as a stand-alone-code.

## 6.5 Medicare Part B

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| ***Vaccine Administration*** | | | |
| Immunization; Influenza | G0008 | Z23 | |
| Immunization; Pneumococcal | G0009 | Z23 | |
| Influenza & Pneumococcal billed together | G0008,G0009 | Z23 | |
| ***Vaccines*** | | | |
| Pneumococcal, 13 Valent (Prevnar 13) | 90670 | Z23 | |
| Pneumococcal 23-Valent (Pneumovax 23) | 90732 | Z23 | |

## 6.6 Medicare Part D (TransactRx)

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| ***Vaccine Administration*** | | | |
| Immunization admin; 1 vaccine | 90471 | Z23 | |
| Immunization admin; each additional vaccine<br>+ add on code* | 90472 | Z23 | |
| ***Vaccines – commonly billed*** | | | |
| Hep A, (Havrix) .5 ml syringe | 90633 | Z23 | 1yr – 18 yrs |
| Hep A, (Havrix) 1ml syringe or vial | 90632 | Z23 | 18 yrs + |
| Hep A, (Vaqta) 1ml vial | 90632 | Z23 | 18 yrs + |
| Hep B, (Engerix-B) 20mcg ml syringe or vial | 90746 | Z23 | 18 yrs + |
| Hep A/HepB, 1ml syringe or vial | 90636 | Z23 | 18 yrs + |
| HPV, types 16,18, (Cervarix) .5ml syringe or vial | 90650 | Z23 | |
| HPV, types 6,11,16,18 (Gardasil) .5ml syringe or vial | 90649 | Z23 | |
| Meningitis, (Menactra) .5ml syringe or vial | 90734 | Z23 | |
| Meningitis, (Menomune) A/C/Y/W-135 .5ml | 90733 | Z23 | |
| Meningitis, (Menveo) .5ml vial | 90734 | Z23 | |
| MMR .5ml vial | 90707 | Z23 | |
| Shingrix, vial | 90750 | Z23 | 50 yrs + |
| Td, (Tenivac) .5ml syringe or vial | 90714 | Z23 | 7 yrs + |
| Tdap, (Adacel) .5ml syringe or vial | 90715 | Z23 | 7 yrs + |
| Tdap, (Boostrix) .5ml syringe or vial | 90715 | Z23 | 7 yrs + |
| Varicella, (Varivax) .5ml vial | 90716 | Z23 | |

*+ add on codes: codes that are always performed in addition to the primary service or procedure & must *Never* be reported as a stand-alone-code.

## 6.7 Influenza Vaccine Products 2018-2019 Season

| Manufacturer | Trade Name | Supply | CPT | Medicare | ICD-10 | Age Group | Medicare Payment Allowance |
|---|---|---|---|---|---|---|---|
| ***Vaccine*** | | | | | | | |
| AstraZeneca/ MedImmune | FluMist (LAIV4) | 0.2 mL single nasal | 90672 | 90672 | Z23 | 2 through 49 years | |
| GlaxoSmithKline | Fluarix (IIV4) | 0.5 mL SD syringe | 90686 | 90686 | Z23 | 6 months & older | |
| ID Biomedical Corp. of Quebec (GSK) | FluLaval (IIV4) | 0.5 mL SD syringe | 90686 | 90686 | Z23 | 6 months & older | |
| | | 5.0 mL MD vial | 90688 | 90688 | Z23 | | |
| Sanofi Pasture, Inc. | Flublok (RIV3) | 0.5 mL SD vial | 90673 | 90673 | Z23 | 18 years & older | |
| Protein Sciences Corporation, a Sanofi company | Flublok (RIV4) | 0.5 mL SD syringe | 90682 | 90682 | Z23 | 18 years & older | $53.373 |
| Sanofi Pasteur, Inc. | Fluzone (IIV4) | 0.25 mL SD syringe | 90685 | 90685 | Z23 | 6 thru 35 months | $21.813 |
| | | 0.5 mL SD syringe | 90686 | 90686 | Z23 | 3 years & older | $19.032 |
| | | 0.5 mL SD vial | 90686 | 90686 | Z23 | 3 years & older | $19.032 |
| | | 5.0 mL MD vial | 90687 | 90687 | Z23 | 6 thru 35 months | $9.403 |
| | | 5.0 mL MD vial | 90688 | 90688 | Z23 | 3 years & older | |
| | Fluzone High-Dose (IIV3-HD) | 0.5 mL SD syringe | 90662 | 90662 | Z23 | 65 years & older | $53.373 |
| | Fluzone Intradermal (IIV4-ID) | 0.1 mL SD micro inj. | 90630 | 90630 | Z23 | 18 thru 64 years | |
| Seqirus (formerly Novartis influenza vaccines and bioCSL | Afluria (IIV3) | 0.5 mL SD syringe | 90656 | 90656 | Z23 | 5 years & older | $19.773 |
| | | 5.0 mL MD vial | 90658 | Q2035 | Z23 | | $18.236 |
| | Afluria (IIV4) | 0.5 mL SD syringe | 90686 | 90686 | Z23 | 5 years & older | |
| | | 5.0 mL MD vial | 90688 | 90688 | Z23 | | $17.835 |
| | Flaud (aIIV3) | 0.5 mL SD syringe | 90653 | 90653 | Z23 | 65 years & older | $54.673 |
| | Fluvirin (IIV3) | 0.5 mL SD syringe | 90656 | 90656 | Z23 | 4 years & older | |
| | | 5.0 mL MD vial | 90658 | Q2037 | Z23 | | |
| | Flucelvax (ccIIV4) | 0.5 mL SD syringe | 90674 | 90674 | Z23 | 4 years & older | $24.047 |
| | | 5.0 mL MD vial | 90756 | 90756 | Z23 | 4 years & older | $22.793 |

SD = single dose, MD = multi-dose, Medicare Payment Allowance effective between 08/01/2018 – 07/31/2019

Visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html for additional Medicare Payment Allowance information

## 6.8 International Travel (Commonly billed)

| Service Description | CPT Code | ICD-10 | Age Restriction |
|---|---|---|---|
| ***Vaccine*** | | | |
| Typhoid, injection | 90691 | Z23 | |
| Typhoid, oral | 90690 | Z23 | |
| Yellow Fever | 90717 | Z23 | |
| ****Additional Vaccines per CDC Recommendations** | | | |
| Medicaid and the MCOs do not cover Typhoid and Yellow Fever | | | |

# Section 7

# Maternal & Child Health Services

## 7.1 Methodologies

**KAN Be Healthy (KBH)** is a Title XIX program which provides preventive health care and immediate remedial care for the prevention, correction, or early control of abnormal conditions.

**KBH Participation/Eligibility:** Beneficiaries who are 20 years of age and under are considered KBH-enrolled participants and are eligible for the KBH program until turning 21 years of age. This program is referred to as Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) at the federal level.

The main source for KBH information is through the state manual. For the current manual, select "KAN Be Healthy – Early and Periodic Screening, Diagnostic, and Treatment" from the dropdown here: https://www.kmap-state- ks.us/Public/providermanuals.asp.

**KBH Billing Guidance:** KBH screening providers must bill each of the 12 components **separately**; When doing a Kan-Be-Healthy and immunizations the same visit, you need to add Modifier 25 to the KBH in order to be paid for both.

The billing options include:

- An evaluation and management (E&M) preventative medicine CPT code (99381 through 99385 or 99391 through 99395) with modifier EP.
- An E&M office visit CPT code (99202 through 99205 or 99213 through 99215) with modifier EP and wellness diagnosis code (V20 through V20.2, V20.31, V20.32, V70.0 and/or V70.3 through V70.9), (Z00.00, Z00.01, Z00.121, Z00.129, Z00.110, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8, Z02.89, Z02.0, Z02.1, Z02.2, Z02.3 Z02.4, Z02.5, Z02.6, Z02.82, Z0281, Z02.83, Z02.89)
- An E&M preventative medicine CPT code without modifier EP and 12 components billed separately.
- An E&M office visit CPT code with wellness diagnosis, without modifier EP and 12 components billed separately.

*Note: There are additional CPT codes that will update one KBH screen only; additional CPT codes update one medical, dental, vision, or hearing KBH screen.*

All KBH screenings must include minimum documentation of the following 12 components. These must be billed separately.

*Note : The **EP modifier** will be strictly informational beginning November 1, 2018. This means that it may still be used to identify an EPSDT service as the modifier code description states. However, it will not be able to be used to bundle a payment. Components must be billed seperatly.*

- Medical history
- Physical growth
- Body systems (cardiovascular/pulmonary gastrointestinal, central nervous system, musculoskeletal, genital/urinary, and integumentary systems)
- Developmental/emotional
- Nutrition
- Health education and anticipatory guidance
- Blood lead screening/testing
- Laboratory (CBC w/differential, other as needed)
- Immunizations
- Hearing screen
- Vision screen
- Dental screen

*See Appendix 11.12 for KBH Specific Billing Reference*

## 7.2 Child Health Visits

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| ***Preventive*** | | |
| New Patient: 1 day - 11 months | 99381 | Z00.121 Z00.129 |
| New Patient: 1 year - 4 years | 99382 | Z00.121 Z00.129 |
| New Patient: 5 years - 11 years | 99383 | Z00.121 Z00.129 |
| New Patient: 12 years - 17 years | 99384 | Z00.121 Z00.129 |
| New Patient: 18 years - 20 years | 99385 | Z00.00 Z00.01 |
| Established Patient: 1 day - 11 months | 99391 | Z00.121 Z00.129 |
| Established Patient: 1 year - 4 years | 99392 | Z00.121 Z00.129 |
| Established Patient: 5 years - 11years | 99393 | Z00.121 Z00.129 |
| Established Patient: 12 years - 17 years | 99394 | Z00.121 Z00.129 |
| Established Patient: 18 years - 20 years | 99395 | Z00.00 Z00.01 |
| ***Evaluation & Management*** | | |
| Nurse Visit | 99211 | |
| Nurse Visit/Assessment – KanCare Only | T1001 | |
| New Patient: Problem focused | 99201 | |
| New Patient: Expanded problem focused | 99202 | |
| New Patient: Detailed | 99203 | |
| New Patient: Comprehensive | 99204 | |
| Established Patient: Problem focused | 99212 | |
| Established Patient: Expanded problem focused | 99213 | |
| Established Patient: Detailed | 99214 | |
| ***Development/Audiology/Vision Screenings*** | | |
| Developmental screening with interpretation and report | 96110 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, pure tone, air only | 92551 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, pure tone audiometry; air only | 92552 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, pure tone audiometry; air and bone | 92553 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, speech threshold | 92555 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, speech threshold; with speech recognition | 92556 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Hearing, comprehensive evaluation & speech recognition (92553,92556) | 92557 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Tympanometry (impedance testing) | 92567 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Acoustic reflex testing, threshold | 92568 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Conditioning play audiometry | 92582 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Evoked response (EEG) audiometry | 92585 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Automated Auditory Brainstem Response | 92586 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Evoked Otoacoustic Emissions; limited | 92587 | Z00.121, Z00.129 Z00.00, Z00.01 |
| Vision, bilateral | 99173 | Z00.121, Z00.129 Z00.00, Z00.01 |
| ***Dental Services*** | | |
| Topical Fluoride Varnish | D1206 | Z01.20 Z01.21 |
| Topical App of Fluoride | D1208 | Z01.20 Z01.21 |

## 7.3 Children's Intervention Services

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| ***Nutrition Services*** | | |
| Nutrition Assessment; initial assessment, each 15 mins | 97802 | Z71.3 |
| Nutrition Assessment; re-assessment, each 15 mins | 97803 | Z71.3 |

## 7.4 Maternal & Infant

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| ***Nurse Assessment-Mother*** | | |
| Prenatal, 1 visit (maximum of 3) | H1000 | Z34.80 |
| Prenatal risk reduction | H1000 | Z34.90 |
| Prenatal, total package of 3 visits | H1005 | Z34.80 |
| Rhogham | 90384 | Z41.8 |
| Postpartum | T1001 | Z39.2 |
| ***Infant Services-Infant*** | | |
| Newborn – 0-28 days | 99502 | Z76.2 |
| Infant – over 28 days | T1001 | |
| ***Nutrition Assessment*** | | |
| Prenatal/Postpartum | S9470 | |
| ***Social Work Assessment-Mother only*** | | |
| Prenatal/Postpartum | H1002 | |
| ***Antepartum Care - Qualified Healthcare Professional (APRN, ARNP, PA, MD)*** | | |
| 1 – 3 visits, see appropriate E/M code(s) | 99211-99215 | Z34.80 |
| 4 - 6 visits | 59425 | Z34.80 |
| 7 or more visits | 59426 | Z34.80 |
| ***Diagnosis Codes ICD-10*** | | |
| Abnormal Glucose complicating pregnancy | | 099.810 |
| Gestational Diabetes | | 024.419 |
| Gestational Diabetes Mellitus, post-partum | | 024.439 |
| Iron tablets | | 099.019 |
| Paperwork (FMLA) | | Z02.79 |
| Prenatal Vitamins | 84591 | Z34.80 |
| Smoking (tobacco). Please see http://www.lung.org/assets/documents/tobacco/billing-guide-for-tobacco.pdf for the appropriate code | | O99.330-O99.335 |
| Supervision of other high risk pregnancy | | 009.899 |
| Threatened spontaneous abortion | | 020.0 |

# Section 8

# Women's Health Services

## 8.1 Methodologies

**Tobacco Cessation Counseling for Pregnant Women:** Policies and Procedures on counseling visits are located in the Physician Services Manual, Section 903.18.

- ✓ Pregnant women that apply for PE and are in Medicaid FFS status are eligible to receive PCM services and Tobacco Cessation Counseling during the same visit.
- ✓ Codes 99406 or 99407 may be billed along with a distinct E&M service if warranted during the same visit.
- ✓ **Modifier 25** must be added to the E&M service, if there are 2 E&M services provided on the same day that are distinct from one another.
- ✓ Wellcare will not pay the health departments for prenatal services.
- ✓ The Cessation counseling must be face-to-face in a clinic setting.
- ✓ For "non-funded WIC" nutritionists who are also qualified as DSPS providers, the counseling visits can be billed (if beyond the two mandatory WIC nutrition counseling visits) in addition to the DSPS Nutritional Counseling service codes.

**340B Pharmaceutical Pricing:** When a covered entity (health department) purchases pharmaceutical products at the 340B price and bills Medicaid/CMOs for the product, the amount billed cannot exceed the entity's actual acquisition cost, plus a dispensing or administration fee as established by the State Medicaid Agency.

**DISCLAIMER**: Not all payers cover dispensing or administrative fees.

## 8.2 Family Planning

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| ***Preventive/Periodic Well Women*** | | |
| New Patient: 12 years - 17 years | 99384 | Z00.121, Z00.129 |
| New Patient: 18 years - 39 years | 99385 | Z00.00, Z00.01 |
| New Patient: 40 years - 64 years | 99386 | Z00.00, Z00.01 |
| Established Patient: 12 years - 17 years | 99394 | Z00.121 |
| Established Patient: 18 years - 39 years | 99395 | Z00.00, Z00.01 |
| Established Patient: 40 years - 64 years | 99396 | Z00.00, Z00.01 |
| ***Examinations*** | | |
| Annual Gynecological examination; New Patient | S0610 | Z01.411, Z01.419 |
| Annual Gynecological examination; Established Patient | S0612 | Z01.411, Z01.419 |
| Annual Gynecological examination; clinical breast exam without pelvic exam | S0613 | Z01.411, Z01.419 |
| ***Evaluation & Management*** | | |
| Nurse Visit | 99211 | |
| Nurse Visit/Assessment – KanCare Only | T1001 | |
| New Patient: Problem focused | 99201 | |
| New Patient: Expanded problem focused | 99202 | |
| New Patient: Detailed | 99203 | |
| New Patient: Comprehensive | 99204 | |
| Established Patient: Problem focused | 99212 | |
| Established Patient: Expanded problem focused | 99213 | |
| Established Patient: Detailed | 99214 | |
| ***Possible ICD-10 Reason for Visit*** | | |
| Anemia | | D64.9 |
| Normal Medical/Lab Exam | | Z00.00 |
| Abnormal Medical/Lab Exam | | Z00.01 |
| Anemia due to blood loss | | D50.0 |
| Anemia due to disturbance of hemoglobin synthesis | | D50.9 |
| BCP Script | | Z30.9 |
| Bacterial Vaginosis (BV) | | N76.0 |
| Breast examination screening | | Z12.39 |
| Breast lump or mass | | N63 |
| Cervicits | | N72 |
| Condyloma-TCA | | A63.0 |
| Counseling | | Z71.9 |
| Currently Pregnant | | Z33.1 |
| Depo-Provera contraceptive surveillance | | Z30.42 |
| Diabetes Mellitus | | E11.9 |
| Employee/school physical | | Z02.89 |
| Foreign body | | T19.2XXA |
| Galactorrhea in female | | N64.3 |
| Health Maintenance | | Z00.8 |
| HPV screening/Pap | | Z11.51 |
| IUD surveillance | | Z30.431 |
| Lipid screening | | Z13.220 |
| Mastitis | | N61 |
| Mastodynia | | N64.4 |
| Molluscum Contagiousm | | B08.1 |
| Nexplanon insertion and/or removal | | Z30.8 |

| | | |
|---|---|---|
| Oral contraceptive surveillance | | Z30.41 |
| Pap abnormal | | R87.89 |
| Pap screening | | Z12.4 |
| Pap screening repeat | | Z01.42 |
| Post-operative wound infection | | T81.4XXA |
| Preconception counseling | | Z31.69 |
| Screening | | Z13.9 |
| Sickle cell anemia | | D57.1 |
| STD counseling | | Z70.8 |
| STD screening | | Z11.3 |
| Symptom related to IUD | | T83.9XXA |
| Thyroid screening | | Z13.29 |
| Urinary tract infection | | N39.0 |
| Yeast Vaginitis | | B37.3 |
| ***Counseling/Interventions*** For proper coding, each provider should research the appropriate codes for the services they provide. Please visit https://www.aafp.org/patient-care/public-health/tobacco-nicotine/coding-reference.html or http://www.lung.org/assets/documents/tobacco/billing-guide-for-tobacco.pdf | | |
| Smoking and tobacco counseling; 3 minutes – 10 minutes | 99406 | |
| Smoking and tobacco counseling; 11 minutes and up | 99407 | |
| Smoking cessation classes, non-physician provider, per session | S9453 | |
| Problems Related to Lifestyle and tobacco use not otherwise specified | | Z720 |
| Nicotine dependence. Use the appropriate code for services provided per AAFP link above | | F17200-F17299 |
| ***Procedures*** | | |
| Insertion, non-biodegradable drug delivery implant | 11981 | |
| Removal, non-biodegradable drug delivery implant | 11982 | |
| Removal *with* reinsertion, non-biodegradable drug delivery implant | 11983 | Z30.433 |
| Insertion of intrauterine device (IUD) | 58300 | Z30.430 |
| Removal of intrauterine device (IUD) | 58301 | Z30.432 |
| Colposcopy of cervix; without biopsy | 57452 | |
| Colposcopy of cervix; with biopsy(s) *and* endocervical curettage | 57454 | |
| Colposcopy of cervix; with biopsy(s) | 57455 | |
| Colposcopy of cervix; with endocervical curettage | 57456 | |
| Colposcopy of cervix; with loop electrode biopsy(s) (LEEP) | 57460 | |
| Colposcopy of cervix; with loop electrode conization of cervix (LEEP) | 57461 | |
| Conization of cervix; loop electrode excision (LEEP) | 57522 | |
| Endrometrial sampling (biopsy) | 58100 | |
| ***Possible Diagnosis Codes (ICD-10)*** | | |
| AGUS | | R87.619 |
| ASCUS | | R87.610 |
| CIN I | | N87.0 |
| CIN II | | N87.1 |
| CIN III | | D06.9 |
| HGSIL | | R87.613 |
| HPV Positive | | R87.810 |
| LGSIL | | R87.612 |
| ***Supplies/Pharmacy*** | | |
| Contraceptive, condom, female | A4268 | Z30.49 |
| Contraceptive, condom, male | A4267 | Z30.49 |
| Contraceptive, diaphragm | A4266 | Z30.8 |
| Contraceptive, oral | S4993 | Z30.41 |

| | | |
|---|---|---|
| Contraceptive, estonogestrel implant (Implanon/Nexplanon) | J7307 | Z30.49 |
| Contraceptive, levonorgestrel releasing intrauterine, 52 mg (Mirena) | J7302 | Z30.430 |
| Contraceptive, intrauterine copper (Paragard) | J7300 | Z30.430 |
| Contraceptive, medroxyprogesterone acetate injection, 1 mg (Depo) | J1050 | Z30.40 |
| Therapeutic, prophylactic or diagnostic injection | 96372 | |

# Section 9

# Adult Health / Miscellaneous Services

## 9.1 Methodologies

**Diagnostic, Screening & Preventive Services (DSPS):** Is a Medicaid category of services solely for public health providers. County Boards of Health are enrolled as the qualified Medicaid provider.

Health departments agree to provide diagnostic, screening and treatment services in an office, clinic, school-based clinic, home, or other similar physical facility within the boundaries of the State of Kansas.

**Nutritional Counseling (Individual & Group):** Dietitians licensed by the Kansas Board of Examiners may bill for Nutritional Counseling. Medicaid reimburses for new patient nutritional assessment, established patient nutritional, counseling and nutritional group counseling visits.

**Additional information:**
MediKan/KanCare will pay for one office visit per client, per date of service. If client receives a clinical service (nurse) and a nutritional counseling (dietician) service on the same day, billing should reflect the appropriate level of services provided; higher "enhanced"" office visit.

To bill MediKan/KanCare for dispensing TB medicine; providers must perform face-to face, system review services warranting a minimal level office visit.

Self Pay Services: Most of our public health departments provide Immunization, Child Health, Women's Health, and Adult Health Services that are covered by our contracted payers. These same services along with other services that are not covered at all may also be provided to patients who have other insurance or are uninsured or underinsured at a set fee. Each County Board of Health sets their own fees for these services and payment may be required at time of service. Listed are a few of the additional services that may be provided at some health departments.

Health departments can bill for any lab that is processed/analyzed in their lab. Health departments can bill for the collection of lab specimens. Some insurance companies will reimburse for lab collection.

Attaching modifier 90 (reference laboratory) to venipuncture (36415) may aid in reimbursement if the outside laboratory that is actually performing the test bills insurance directly for the lab tests. Some insurance companies will deny lab collection as "content of service" to the E/M procedure code.

For situations where clients bring in medication/injectables (B12, hormone, allergy, etc.), many departments provide this service for a fee and utilize CPT code 96372, "Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular."

| 9.2 Adult Health – Preventative/STD/TB/Nutritional Counseling/MISC | | |
|---|---|---|
| **Service Description** | **CPT Code** | **Notes** |
| ***Preventative*** | | |
| New Patient: 18 years - 39 years | 99385 | |
| New Patient: 40 years - 64 years | 99386 | |
| Established Patient: 18 years - 39 years | 99395 | |
| Established Patient: 40 years - 64 years | 99396 | |
| ***Evaluation & Management*** | | |
| Nurse Visit | 99211 | |
| Nurse Visit/Assessment – KanCare Only | T1001 | |
| New Patient: Problem focused | 99201 | |
| New Patient: Expanded problem focused | 99202 | |
| New Patient: Detailed | 99203 | |
| New Patient: Comprehensive | 99204 | |
| Established Patient: Problem focused | 99212 | |
| Established Patient: Expanded problem focused | 99213 | |
| Established Patient: Detailed | 99214 | |
| ***Treatment*** | | |
| TCA treatment | E946.4 | A63.0 |
| Azithromycin (chlamydia) | J0456 | A74.9 |
| Bicillin (syphilis) | E930.32 | A53.9 |
| Cefrtiaxone (gonorrhea) | J0696 | A54.9 |
| Doxycyline (syphilis) | E930.4 | A53.9 |
| Metronidazole (trich) | S0030 | A59.9 |
| ***Allergy Injections*** | | |
| Allergy injection; single injection | 95115 | |
| Allergy injection; 2 or more injections | 95117 | |
| ***Nutritional Counseling*** | | |
| Nutrition Assessment individual; Initial assessment, each 15 mins | 97802 | |
| Nutrition Assessment individual; re-assessment, each 15 mins | 97803 | |
| Nutrition Assessment group; Initial assessment, each 15 mins | 97804 | |
| ***Special Evaluations & Management Services*** | | |
| Basic life/Disability evaluation | 99450 | |
| Work related/Medical Disability | 99456 | |

## 9.3 Miscellaneous Services

**Fees for these services are set by the local County Boards of Health.**

Prepare Immunization & Hearing, Vision, Dental Certificates w/o service
Blood Pressure, Height, and Weight Checks
Copy of Medical Records
Fax Medical Records
General Lab Services
Health Check Services
International Travel Services
Lice and Scabies Checks
Refugee Screening Services
Childcare Provider Physicals
Sports Physicals w/ Certificate
SSI Services

# Section 10
# Laboratory Services

## 10.1 Laboratory

| Service Description | CPT Code | ICD-10 |
|---|---|---|
| ***Services*** | | |
| 2 Hour Glucose | 82950 | Z86.32 |
| Blood, occult | 82270 | |
| Blood lead | 83655 | Z13.88 (screen), Z77.011 (exposure) |
| Blood sugar | 82948 | |
| Chlamydia trachomatis; amplified probe technique | 87491 | |
| Cholesterol, serum or whole blood | 82465 | |
| Complete blood count (CBC) | 85025 | |
| Finger/Heal stick | 36416 | |
| Gastrin | 82941 | |
| Glucagon tolerance test | 82946 | |
| Glucose | 82947 | |
| Glucose, blood by glucose monitoring device | 82962 | |
| Gonadotropin, chorionic (HCG); qualitative | 84703 | |
| Gonorrhea; amplified probe technique | 87591 | |
| Handling, conveyance of specimen to lab | 99000 | |
| Hematocrit | 85013 | |
| Hemoglobin | 85018 | Z13.0 |
| Hemoglobin; glycosylated (A1C) | 83036 | Z13.1 |
| HEP C | 86803 | Z04.9 |
| HIV-1; antibody | 86701 | |
| HIV-2; antibody | 86702 | |
| HIV-1 and HIV-2; antibody; | 86703 | Z11.59, Z04.9 |
| HIV-1; infectious agent | 87390 | |
| HPV | 87624 | Z01.419 |
| Pap Smear | 88142 | |
| Rubella; antibody | 86762 | |
| Smear; wet mount (eg. KOH prep, Fern Test) | 87210 | N76.0, N72, B37.3 |
| Smear; Gram or Giemsa stain | 87205 | |
| Surgical pathology (biopsy) | 88305 | |
| Syphilis test (eg. RPR, VDRL, ART) | 86592 | Z20.2 |
| TB cell mediated immunity response measurement; gamma | 86480 | |
| TB skin Test | 86580 | Z11.1 |
| Tissue exam by KOH, skin, hair, nails | 87220 | |
| Urinalysis; with microscopy | 81000 | R39.9, Z78.9, R82.90 |
| Urinalysis; automated, with microscopy | 81001 | |
| Urinalysis; non-automated, without microscopy | 81002 | |
| Urinalysis; automated, without microscopy | 81003 | |
| Urine pregnancy test, by visual method | 81025 | Z32.00, Z32.01(+), Z32.02 (-) |
| Venipuncture | 36415 | |

# Section 11

# Appendices

## 11.1 Component Requirements for Office/Home Visits

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a recognized health care provider and reported by a specific CPT code(s).

A new patient is one who has not received any professional services from the physician, health care provider or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.

**The Level of Service is based on the following Components:** For **all of the key components**, i.e., history, examination, and medical decision-making, must meet or exceed the stated requirements to qualify for a particular level of office visit.

For **two of the three components**, i.e., history, examination, and medical decision-making, must meet or exceed the state requirements to qualify for a particular level of office visit.

When counseling and/or coordination of care dominates more than 50% of the face-to-face encounter, then **time** shall be considered the controlling factor to qualify for a particular level of office visit.

# Component Requirements for Office Visits

| Office or Other Outpatient Services | | | | | | |
|---|---|---|---|---|---|---|
| **Patient:** New | | | | | | |
| **Required Components:** 3/3 | | | | | | |
| **Code** | | 99201 | 99202 | 99203 | 99204 | 99205 |
| Required Key Components | **History and Exam (#1 and #2)** | | | | | |
| | Problem Focused | x | | | | |
| | Expanded Problem Focused | | x | | | |
| | Detailed | | | x | | |
| | Comprehensive | | | | x | x |
| | **Medical Decision Making (#3)** | | | | | |
| | Straightforward | x | x | | | |
| | Low | | | x | | |
| | Moderate | | | | x | |
| | High | | | | | x |
| Contributory Factors | **Presenting Problem (Severity) (#1)** | | | | | |
| | Self-Limited or Minor | x | | | | |
| | Low to Moderate | | x | | | |
| | Moderate | | | x | | |
| | Moderate to High | | | | x | x |
| | **Counseling and Coordination of Care (#2 and #3)** See E/M Guidelines | | | | | |
| | **Typical Face-to-Face Time (#4)** | | | | | |
| | Minutes | 10 | 20 | 30 | 45 | 60 |

| Office or Other Outpatient Services | | | | | | |
|---|---|---|---|---|---|---|
| **Patient:** Established | | | | | | |
| **Required Components:** 2/3 | | | | | | |
| **Code** | | 99211 | 99212 | 99213 | 99214 | 99215 |
| Required Key Components | **History and Exam (#1 and #2)** | | | | | |
| | Problem Focused | N/A | x | | | |
| | Expanded Problem Focused | | | x | | |
| | Detailed | | | | x | |
| | Comprehensive | | | | | x |
| | **Medical Decision Making (#3)** | | | | | |
| | Straightforward | N/A | x | | | |
| | Low | | | x | | |
| | Moderate | | | | x | |
| | High | | | | | x |
| Contributory Factors | **Presenting Problem (Severity) (#1)** | | | | | |
| | Minimal | x | | | | |
| | Self-Limited or Minor | | x | | | |
| | Low to Moderate | | | x | | |
| | Moderate to High | | | | x | x |
| | **Counseling and Coordination of Care (#2 and #3)** See E/M Guidelines | | | | | |
| | **Typical Face-to-Face Time (#4)** | | | | | |
| | Minutes | 5 | 10 | 15 | 25 | 40 |

# Component Requirements for Home Visits

| Home Services | | | | | | |
|---|---|---|---|---|---|---|
| **Patient:** New | | | | | | |
| **Required Components:** 3/3 | | | | | | |
| **Code** | | 99341 | 99342 | 99343 | 99344 | 99345 |
| Required Key Components | **History and Exam (#1 and #2)** | | | | | |
| | Problem Focused | x | | | | |
| | Expanded Problem Focused | | x | | | |
| | Detailed | | | x | | |
| | Comprehensive | | | | x | x |
| | **Medical Decision Making (#3)** | | | | | |
| | Straightforward | x | | | | |
| | Low | | x | | | |
| | Moderate | | | x | x | |
| | High | | | | | x |
| Contributory Factors | **Presenting Problem (Severity) (#1)** | | | | | |
| | Low | x | | | | |
| | Moderate | | x | | | |
| | Moderate to High | | | x | | |
| | High | | | | x | |
| | Unstable/Significant New Problem | | | | | x |
| | **Counseling and Coordination of Care (#2 and #3)** See E/M Guidelines | | | | | |
| | **Typical Face-to-Face Time (#4)** | | | | | |
| | Minutes | 20 | 30 | 45 | 60 | 75 |

| Home Services | | | | | |
|---|---|---|---|---|---|
| **Patient:** Established | | | | | |
| **Required Components:** 2/3 | | | | | |
| **Code** | | 99347 | 99348 | 99349 | 99350 |
| Required Key Components | **Interval History and Exam (#1 and #2)** | | | | |
| | Problem Focused | x | | | |
| | Expanded Problem Focused | | x | | |
| | Detailed | | | x | |
| | Comprehensive | | | | x |
| | **Medical Decision Making (#3)** | | | | |
| | Straightforward | x | | | |
| | Low | | x | | |
| | Moderate | | | x | |
| | Moderate to High | | | | x |
| Contributory Factors | **Presenting Problem (Severity) (#1)** | | | | |
| | Self-Limited or Minor | x | | | |
| | Low to Moderate | | x | | |
| | Moderate to High | | | x | |
| | Moderate to High/Unstable/ Significant New Problem | | | | x |
| | **Counseling and Coordination of Care (#2 and #3)** See E/M Guidelines | | | | |
| | **Typical Face-to-Face Time (#4)** | | | | |
| | Minutes | 15 | 25 | 40 | 60 |

## 11.2 Vaccine Route of Administration Codes

### *Administration without counseling – All ages*

| Route | Injection | Route | Oral / Intranasal |
|---|---|---|---|
| **CPT Code** | **Description** | **CPT Code** | **Description** |
| **90471** | Immunization administration by injection; 1 vaccine (single or combination vaccine/toxoid) | **90473** | Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) |
| **+ 90472** | Immunization administration by injection; *each additional* vaccine (single or combination vaccine/toxoid) | **+ 90474** | Immunization administration by intranasal or oral route; *each additional* vaccine (single or combination vaccine/toxoid) |

### *Administration with counseling – 0 – 18 years of age*

| Any Route | |
|---|---|
| **CPT Code** | **Description** |
| **90460** | Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; 1 or only component or each vaccine or toxoid |
| **+ 90461** | Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered |

### *Medicare Administration Codes*

| Route | Injection | Route | Oral / Intranasal |
|---|---|---|---|
| **CPT Code** | **Description** | **CPT Code** | **Description** |
| **90471** | Immunization administration by injection; 1 vaccine (single or combination vaccine/toxoid) | **90473** | Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) |
| **+ 90472** | Immunization administration by injection; *each additional* vaccine (single or combination vaccine/toxoid) | **+ 90474** | Immunization administration by intranasal or oral route; *each additional* vaccine (single or combination vaccine/toxoid) |
| **G0008** | Influenza vaccine administration | | |
| **G0009** | Pneumococcal vaccine administration | | |
| **G0010** | Hep B vaccine administration | | |

## 11.3 RELATED LINKS

Immunization Schedules: http://www.cdc.gov/vaccines/schedules/index.html

Advance Beneficiary of Notice and Instructions: http://www.cms.gov/Outreach-and-Education/Medicare- Learning-Network-MLN/MLNProducts/downloads/ABN_ Booklet_ICN006266.pdf

Aetna office resources for healthcare professionals: https://www.aetna.com/health-care-professionals.html

AMA Coding & Billing: https://www.ama-assn.org/practice-management/coding-billing

Amerigroup of Kansas provider representatives: https://providers.amerigroup.com/ProviderDocuments/KSKS_ProviderReps.pdf

Amerigroup Provider Manual: https://providers.amerigroup.com/providerdocuments/ksks_prov_manual.pdf

Ask-EDI: http://www.ask-edi.com/

Availity Log in: https://apps.availity.com/availity/

BCBS Health Department Billing Guidelines: http://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/Health-Department-Billing-Guidelines.pdf

Blue Cross and Blue Shield of Kansas, Provider Resources: http://www.bcbsks.com/CustomerService/Providers/professional.shtml

Centers for Medicare & Medicaid Services: http://www.cms.gov/

Cigna: http://www.cigna.com/

Coventry Direct Provider: https://www.directprovider.com/

Coventry Provider Representative: http://chckansas.coventryhealthcare.com/ services-and-support/providers/provider-rep-territory/index.htm

Emdeon: http://www.emdeon.com/

KMAP training for LHD (Professional) billers: https://www.kmap-state-ks.us/Public/Workshop%20Schedule/Workshop%20Materials.asp

KMAP Publications: https://www.kmap-state-ks.us/Public/Publications.asp

Medicare Enrollment and Claim Submission Guidelines: https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html

Medicare (C-SNAP) login: https://www.medicareinfo.com/apps/cms/home

Medicare WPS: https://www.wpsgha.com/

Navinet: https://navinet.navimedix.com/sign-in?ReturnUrl=/Main.asp

Optum Health Payment Services: https://myservices.optumhealthpaymentservices.com/registrationSignIn.do

Payspan: https://www.payspanhealth.com/nps/login.aspx

Sunflower Manuals and Guides: http://www.sunflowerhealthplan.com/for-providers/provider-resources/manuals-guides/

Sunflower State Health Plan Provider Representative Contacts and Territory Map: http://www.sunflowerhealthplan.com/for-providers/provider-resources/

Sunflower State Health: https://provider.sunflowerstatehealth.com/

TransactRx: https://www.mytransactrx.com

United Healthcare Community Plan. Click on United Healthcare Provider Contact List and Physical Health Provider Advocate Map: http://www.uhccommunityplan.com/ health-professionals/ks.html

United Healthcare Approved Provider Administrative Guide: http://www.uhccommunityplan.com/kansas-03.html

United Healthcare Online: https://www.unitedhealthcareonline.com/

WPC – Washington Publishing Company provides reason and remark code sets used to report payment adjustments in remittance advice transactions and in some coordination-of-benefits transactions: http://www.wpc-edi.com/reference/

## 11.4 ACRONYMS

| | |
|---|---|
| ACA | Affordable Care Act |
| AMA | American Medical Association |
| BCBS | Blue Cross Blue Shield |
| CMS | Centers for Medicare & Medicaid Services |
| COB | Coordination of Benefits |
| COBRA | Consolidated Omnibus Budget Reconciliation Act |
| CPT | Current Procedural Terminology |
| DCI | Duplicate Coverage Inquiry |
| DME | Durable Medical Equipment |
| DOB | Date of Birth |
| DOS | Date of Service |
| DX | Diagnosis, or Diagnosis Code (ICD-10) |
| EDI | Electronic Data Interchange |
| EFT | Electronic Funds Transfer |
| EIN | Employer Identification Number |
| E/M | Evaluation & Management |
| EMR | Electronic Medical Record |
| EOB | Explanation of Benefits |
| EOP | Explanation of Payment |
| EOMB | Explanation of Medicare Benefits |
| EPSDT | Early & Periodic Screening, Diagnostic, & Treatment |
| ERA | Electronic Remittance Advice |
| ERISA | Employee Retirement Income Security Act of 1974 |
| FFS | Fee-for-Service |
| FI | Fiscal Intermediary |
| GHP | Group Health Plan |
| HC | Health Check |
| HCPCS | Healthcare Common Procedure Coding System |
| HIC | Health Insurance Claim |
| HIPAA | Health Insurance Portability & Accountability Act |
| HMO | Health Maintenance Organization |
| HSA | Health Savings Account |
| ICD-9 | International Classification of Diseases, 9th edition |
| ICD-10 | International Classification of Diseases, 10th edition |
| MAC | Medicare Administrative Contractor |
| MCO | Managed Care Organization |
| MSP | Medicare Secondary Payer |
| N/C | Non-Covered Charge |
| NDC | Nation Drug Code |
| NEC | Not Elsewhere Classifiable |
| NOS | Not Otherwise Classifiable |
| NPI | National Provider Identifier |
| OIG | Office of Inspector General |
| PCP | Primary Care Provider |
| PEC | Pre-existing Condition |
| PHI | Protected Health Information |
| POS | Place of Service |
| PPO | Preferred Provider Organization |
| PTAN | Provider Transaction Access Number |
| QMB | Qualified Medicare Beneficiary |
| RA | Remittance Advice |
| RVU | Relative Value Unit |
| SOF | Signature on File |
| TAR | Treatment Authorization Request |
| TIN | Tax Identification Number |
| TOS | Type of Service |
| TPA | Third Party Administrator |
| TPL | Third Party Liability |
| UB | Uniform Billing |
| UR | Utilization Review |

## 11.5 DEFINITIONS

**ACA** – Affordable Care Act. Also referred to as "ObamaCare". A federal law enacted in 2010 intended to increase healthcare coverage and make it more affordable.

**Accept Assignment** – When a provider accepts as "full-payment" the amount paid on a claim by the insurance company, excluding the coinsurance, deductible or co-pay due from the patient

**Adjusted Claim** – A claim that has been corrected, due to an error during submission or payment, which results in a credit or payment to the provider

**Allowed Amount** – The reimbursement rate that the insurance company will pay for a procedure.

**AMA** - American Medical Association. The AMA is the largest association of Doctors in the United States. They publish the Journal of American Medical Association which is one of the most widely circulated medical journals in the world.

**Aging** - One of the medical billing terms referring to the unpaid insurance claims or patient balances that are due past 30 days. Most medical billing software's have the ability to generate a separate report for insurance aging and patient aging. These reports typically list balances by 30, 60, 90, and 120 day increments.

**Appeal** - When an insurance plan does not pay for treatment, an appeal (either by the provider or patient) is the process of objecting this decision. The insurer may require documentation when processing an appeal and typically has a formal policy or process established for submitting an appeal. Many times the process and associated forms can be found on the insurance provider's web site.

**Applied to Deductible** - You typically see these medical billing terms on the patient statement. This is the amount of the charges, determined by the patients insurance plan, the patient owes the provider. Many plans have a maximum annual deductible that once met is then covered by the insurance provider.

**Assignment of Benefits** - Insurance payments that are paid to the doctor or hospital for a patient's treatment.

**Beneficiary** - Person or persons covered by the health insurance plan.

**Blue Cross Blue Shield (BCBS)** - An organization of affiliated insurance companies (approximately 450), independent of the association (and each other), that offer insurance plans within local regions under one or both of the association's brands (Blue Cross or Blue Shield). Many local BCBS associations are non-profit BCBS sometimes acts as administrators of Medicare in many states or regions.

**Capitation** - A fixed payment paid per patient enrolled over a defined period of time, paid to a health plan or provider. This covers the costs associated with the patients' health care services. This payment is not affected by the type or number of services provided.

**Carrier** – The insurance company or "carrier" the patient has a contract with to provide health insurance

**CHAMPUS** - Civilian Health and Medical Program of the Uniformed Services. Recently renamed TRICARE. This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors.

**Charity Care/Sliding Scale** - When medical care is provided at no cost or at reduced cost to a patient that cannot afford to pay.

**Clean Claim** - Medical billing term for a complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly.

**Clearinghouse** - This is a service that transmits claims to insurance carriers. Prior to submitting claims the clearinghouse scrubs claims and checks for errors. This minimizes the amount of rejected claims as most errors can be easily corrected. Clearinghouses electronically transmit claim information that is compliant with the strict HIPPA standards (this is one of the medical billing terms we see a lot more of lately).

**CMS** - Centers for Medicaid and Medicare Services. Federal agency which administers Medicare, Medicaid, HIPPA, and other health programs. Formerly known as the HCFA (Health Care Financing Administration). You'll notice that CMS is the source of a lot of medical billing terms.

**CMS 1500** - Medical claim form established by CMS to submit paper claims to Medicare and Medicaid. Most commercial insurance carriers also require paper claims be submitted on a CMS-1500. The form is distinguished by its red ink.

**Coding** - Medical Billing Coding involves taking the doctors notes from a patient visit and translating them into the proper ICD-10 code for diagnosis and CPT codes for treatment.

**COBRA Insurance** - This is health insurance coverage available to an individual and their dependents after becoming unemployed - either voluntary or involuntary termination of employment for reasons other than gross misconduct. Because it does not typically receive company matching, it's typically more expensive than insurance the cost when employed but does benefit from the savings of being part of a group plan. Employers must extend COBRA coverage to employees dismissed for a. COBRA stands for Consolidated Omnibus Budget Reconciliation Act which was passed by Congress in 1986. COBRA coverage typically lasts up to 18 months after becoming unemployed and under certain conditions extend up to 36 months.

**Co-Insurance** - Percentage or amount defined in the insurance plan for which the patient is responsible. Most plans have a ratio of 90/10 or 80/20, 70/30, etc. For example, the insurance carrier pays 80% and the patient pays 20%.

**Contractual Adjustment** - The amount of charges a provider or hospital agrees to write off and not charge the patient per the contract terms with the insurance company.

**Coordination of Benefits** - When a patient is covered by more than one insurance plan. One insurance carrier is designated as the primary carrier and the other as secondary.

**Co-Pay** - Amount paid by patient at each visit as defined by the insured plan.

**CPT Code** - Current Procedural Terminology. This is a 5-digit code assigned for reporting a procedure performed by the physician. The CPT has a corresponding diagnosis code. Established by the American Medical Association. This is one of the medical billing terms we use a lot.

**Credentialing** - This is an application process for a provider to participate with an insurance carrier. Many carriers now request credentialing through CAQH. CAQH credentialing process is a universal system now accepted by insurance company networks.

**Credit Balance** - The balance that's shown in the "Balance" or "Amount Due" column of your account statement with a minus sign after the amount (for example $50-). It may also be shown in parenthesis; ($50). The provider may owe the patient a refund.

**Crossover claim** - When claim information is automatically sent from Medicare the secondary insurance such as Medicaid.

**Date of Service (DOS)** - Date that health care services were provided.

**Deductible** - amount patient must pay before insurance coverage begins. For example, a patient could have a $1000 deductible per year before their health insurance will begin paying. This could take several doctor's visits or prescriptions to reach the deductible.

**Demographics** - Physical characteristics of a patient such as age, sex, address, etc. necessary for filing a claim.

**DOB** - Abbreviation for Date of Birth

**Downcoding** - When the insurance company reduces the code (and corresponding amount) of a claim when there is no documentation to support the level of service submitted by the provider. The insurers' computer processing system converts the code submitted down to the closest code in use which usually reduces the payment.

**Durable Medical Equipment** – Medical Supplies

**Duplicate Coverage Inquiry (DCI)** - Request by an insurance company or group medical plan by another insurance company or medical plan to determine if other coverage exists.

**Dx** - Abbreviation for diagnosis, or diagnosis code (ICD-10 code).

**Electronic Claim** - Claim information is sent electronically from the billing software to the clearinghouse or directly to the insurance carrier. The claim file must be in a standard electronic format as defined by the receiver.

**Electronic Funds Transfer (EFT)** - An electronic paperless means of transferring money. This allows funds to be transferred, credited, or debited to a bank account and eliminates the need for paper checks.

**E/M** - Evaluation and Management section of the CPT codes. These are the CPT codes 99201 thru 99499 most used by physicians or other qualified staff to access (or evaluate) patients' treatment needs.

**EMR** - Electronic Medical Records. This is a medical record in digital format of a patient's hospital or provider treatment.

**Enrollee** - Individual covered by health insurance.

**EOB** - Explanation of Benefits. One of the medical billing terms for the statement that comes with the insurance company payment to the provider explaining payment details, covered charges, write offs, and patient responsibilities and deductibles.

**ERA** - Electronic Remittance Advice. This is an electronic version of an insurance EOB that provides details of insurance claim payments. These are formatted in according to the HIPAA X12N 835 standard.

**ERISA** - Employee Retirement Income Security Act of 1974. This law established the reporting, disclosure of grievances, and appeals requirements and financial standards for group life and health. Self-insured plans are regulated by this law.

**Fee For Service** - Insurance where the provider is paid for each service or procedure provided. Typically allows patient to choose provider and hospital. Some policies require the patient to pay provider directly for services and submit a claim to the carrier for reimbursement. The trade-off for this flexibility is usually higher deductibles and co-pays.

**Fee Schedule** - Cost associated with each treatment CPT medical billing codes.

**Financial Responsibility** - The portion of the charges that are the responsibility of the patient or insured.

**Fiscal Intermediary (FI)** - A Medicare representative who processes Medicare claims.

**Formulary** - A list of prescription drug costs which an insurance company will provide reimbursement for.

**Fraud** - When a provider receives payment or a patient obtains services by deliberate, dishonest, or misleading means.

**GHP** - Group Health Plan. A means for one or more employer who provide health benefits or medical care for their employees (or former employees).

**Group Name** - Name of the group or insurance plan that insures the patient.

**Group Number** - Number assigned by insurance company to identify the group under which a patient is insured.

**Guarantor** - A responsible party and/or insured party who is not a patient.

**HCFA** - Health Care Financing Administration. Now known as CMS (see above in Medical Billing Terms).

**HCPCS** - Health Care Financing Administration Common Procedure Coding System. (Pronounced "hick-picks"). A standardized medical coding system used to describe specific items or services provided when delivering health services. May also be referred to as a "procedure code" in the medical billing glossary. The three HCPCS levels are:

- Level I - American Medical Association's Current Procedural Terminology (CPT) codes.
- Level II - The alphanumeric codes which include mostly non-physician items or services such as medical supplies, ambulatory services, prosthesis, etc. These are items and services not covered by CPT (Level I) procedures.
- Level III - Local codes used by state Medicaid organizations, Medicare contractors, and private insurers for specific areas or programs.

**Health Savings Account** - A tax advantaged medical savings account available to employees who are enrolled in a High-Deductible health plan. This account is to be used for medical expenses only.

**Healthcare Insurance** - Insurance coverage to cover the cost of medical care necessary as a result of illness or injury. May be an individual policy or family policy which covers the beneficiary's family members. May include coverage for disability or accidental death or dismemberment.

**Healthcare Provider** - Typically a physician, hospital, nursing facility, or laboratory that provides medical care services. Not to be confused with insurance providers or the organization that provides insurance coverage.

**Health Care Reform Act** - Health care legislation championed by President Obama in 2010 to provide improved individual health care insurance or national health care insurance for Americans. Also referred to as the Health Care Reform Bill or the Obama Health Care Plan.

**HIC** - Health Insurance Claim. This is a number assigned by the Social Security Administration to a person to identify them as a Medicare beneficiary. This unique number is used when processing Medicare claims.

**HIPAA** - Health Insurance Portability and Accountability Act. Several federal regulations intended to improve the efficiency and effectiveness of health care. HIPAA has introduced a lot of new medical billing terms into our vocabulary lately.

**HMO** - Health Maintenance Organization. A type of health care plan that places restrictions on treatments.

**ICD-9 Code** - 9th revision of the International Classification of Diseases, also known as ICD-9-CM, is a system used to assign 3 to 5 digit codes to patient diagnoses.

**ICD-10 Code** - 10th revision of the International Classification of Diseases, also known as ICD-10-CM, is a system used to assign 3 to 7 digit codes to patient diagnoses. Includes additional digits to allow more available codes. ICD-10 was implemented in October 2015.

**Indemnity** - Also referred to as fee-for-service. This is a type of commercial insurance were the patient can use any provider or hospital.

**In-Network (or Participating)** - An insurance plan in which a provider signs a contract to participate in. The provider agrees to accept a discounted rate for procedures.

**MAC** - Medicare Administrative Contractor. Contractors who process Medicare claims.

**Managed Care Plan** - Insurance plan requiring patient to see doctors and hospitals that are contracted with the managed care insurance company. Medical emergencies or urgent care are exceptions when out of the managed care plan service area.

**Maximum Out of Pocket** - The maximum amount the insured is responsible for paying for eligible health plan expenses. When this maximum limit is reached, the insurance typically then pays 100% of eligible expenses.

**Medical Assistant** - A health care worker who performs administrative and clinical duties in support of a licensed health care provider such as a physician, physician's assistant, nurse, nurse practitioner, etc.

**Medical Coder** - Analyzes patient charts and assigns the appropriate CPT and ICD-10 codes, and any related CPT modifiers.

**Medical Billing Specialist** - Processes insurance claims for payment of services performed by a physician or other health care provider. Ensures patient medical billing codes, diagnosis, and insurance information are entered correctly and submitted to insurance payer. Enters insurance payment information and processes patient statements and payments. Performs tasks vital to the financial operation of a practice. Knowledgeable in medical billing terminology.

**Medical Necessity** - Medical service or procedure that is performed on for treatment of an illness or injury that is not considered investigational, cosmetic, or experimental.

**Medical Record Number** - A unique number assigned by the provider or health care facility to identify the patient medical record.

**MSP** - Medicare Secondary Payer.

**Medical Savings Account** - Tax exempt account for paying medical expenses administered by a third party to reimburse a patient for eligible health care expenses. Typically provided by employer where the employee contributes regularly to the account before taxes and submits claims or receipts for reimbursement. Sometimes also referred to in medical billing terminology as a Medical Spending Account.

**Medicare** - Insurance provided by federal government for people over 65 or people under 65 with certain restrictions. There are 4 parts:

- **Medicare Part A** - Hospital coverage
- **Medicare Part B** - Physicians visits and outpatient procedures
- Medicare Advantage Plans, sometimes called **Medicare Part C** or MA Plans, are offered by private companies approved by Medicare.
- **Medicare Part D** - Medicare insurance for prescription drug costs for anyone enrolled in Medicare Part A or B.

**Medicare Coinsurance Days** - Medical billing terminology for inpatient hospital coverage from day 61 to day 90 of a continuous hospitalization. The patient is responsible for paying for part of the costs during those days. After the 90th day, the patient enters "Lifetime Reserve Days."

**Medicare Donut Hole** - The gap or difference between the initial limits of insurance and the catastrophic Medicare Part D coverage limits for prescription drugs.

**Medicaid** - Insurance coverage for low income patients. Funded by Federal and state government and administered by states.

**Medigap** - Medicare supplemental health insurance for Medicare beneficiaries which may include payment of Medicare deductibles, co-insurance and balance bills, or other services not covered by Medicare.

**Modifier** - Added to a CPT treatment code to provide additional information to insurance payers for procedures or services that have been altered or "modified" in some way. Modifiers are important to explain additional procedures and obtain reimbursement for them.

**N/C** - Non-Covered Charge. A procedure not covered by the patients' health insurance plan.

**NEC** - Not Elsewhere Classifiable. Medical billing terminology used in ICD when information needed to code the term in a more specific category is not available.

**Network Provider** - Health care provider who is contracted with an insurance provider to provide care at a negotiated cost.

**Non-participation (Non-Par)** - When a healthcare provider chooses not to accept Medicare approved payment amounts as payment in full.

**NOS** - Not Otherwise Specified. Used in ICD for unspecified diagnosis.

**NPI Number** - National Provider Identifier. A unique 10 digit identification number required by HIPAA and assigned through the National Plan and Provider Enumeration System (NPPES).

**OIG** - Office of Inspector General - Part of department of Health and Human Services. Establish compliance requirements to combat healthcare fraud and abuse. Has guidelines for billing services and individual and small group physician practices.

**Out-of Network (or Non-Participating)** - A provider that does not have a contract with the insurance carrier. Patients usually responsible for a greater portion of the charges or may have to pay all the charges for using an out-of network provider.

**Out-Of-Pocket Maximum** - The maximum amount the patient has to pay under their insurance policy. Anything above this limit is the insurers' obligation. These Out-of-pocket maximums can apply to all coverage or to a specific benefit category such as prescriptions.

**Outpatient** - Typically treatment in a physician's office, clinic, or day surgery facility lasting less than one day.

**Patient Responsibility** - The amount a patient is responsible for paying that is not covered by the insurance plan.

**PCP** - Primary Care Physician - Usually the physician who provides initial care and coordinates additional care if necessary.

**POS** - Point-of-Service plan. Medical billing terminology for a flexible type of HMO (Health Maintenance Organization) plan where patients have the freedom to use (or self-refer to) non-HMO network providers. When a non-HMO specialist is seen without referral from the Primary Care Physician (self-referral), they have to pay a higher deductible and a percentage of the coinsurance.

**POS (Used on Claims)** - Place of Service. Medical billing terminology used on medical insurance claims - such as the CMS 1500 block 24B. A two-digit code which defines where the procedure was performed. For example, 71 is for the Health Departments and 12 is for home.

**PPO** - Preferred Provider Organization. Commercial insurance plan where the patient can use any doctor or hospital within the network. Similar to an HMO.

**Practice Management Software** - software used for the daily operations of a provider's office. Typically used for appointment scheduling and billing.

**Preauthorization** - Requirement of insurance plan for primary care doctor to notify the patient insurance carrier of certain medical procedures (such as outpatient surgery) for those procedures to be considered a covered expense.

**Pre-Certification** - Sometimes required by the patients insurance company to determine medical necessity for the services proposed or rendered. This doesn't guarantee the benefits will be paid.

**Predetermination** - Maximum payment insurance will pay towards surgery, consultation, or other medical care - determined before treatment.

**Pre-existing Condition (PEC)** - A medical condition that has been diagnosed or treated within a certain specified period of time just before the patient's effective date of coverage. A Pre-existing condition may not be covered for a determined amount of time as defined in the insurance terms of coverage (typically 6 to 12 months).

**Pre-existing Condition Exclusion** - When insurance coverage is denied for the insured when a pre-existing medical condition existed when the health plan coverage became effective.

**Premium** - The amount the insured or their employer pays (usually monthly) to the health insurance company for coverage.

**Privacy Rule** - The HIPAA privacy standard establishes requirements for disclosing what the HIPAA privacy law calls Protected Health Information (PHI). PHI is any information on a patient about the status of their health, treatment, or payments.

**Provider** - Physician or medical care facility (hospital) who provides health care services.

**PTAN** - Provider Transaction Access Number. Also known as the legacy Medicare number.

**Referral** - When one provider (usually a family doctor) refers a patient to another provider (typically a specialist).

**Relative Value Unit** – Measure of value used by Medicare to determine how much to reimbursement for a procedure by using a formula

**Remittance Advice (R/A)** - A document supplied by the insurance payer with information on claims submitted for payment. Contains explanations for rejected or denied claims. Also referred to as an EOB (Explanation of Benefits).

**Responsible Party** - The person responsible for paying a patient's medical bill. Also referred to as the guarantor.

**Self-Referral** - When a patient sees a specialist without a primary physician referral.

**Self Pay** - Payment made at the time of service by the patient.

**Secondary Insurance Claim** - claim for insurance coverage paid after the primary insurance makes payment. Secondary insurance is typically used to cover gaps in insurance coverage.

**Secondary Procedure** - When a second CPT procedure is performed during the same physician visit as the primary procedure.

**Security Standard** - Provides guidance for developing and implementing policies and procedures to guard and mitigate compromises to security. The HIPAA security standard is kind of a sub-set or compliment to the HIPAA privacy standard. Where the HIPAA policy privacy requirements apply to all patient Protected Health Information (PHI), HIPAA policy security laws apply more specifically to electronic PHI.

**SOF** - Signature on File.

**Specialist** - Physician who specializes in a specific area of medicine, such as urology, cardiology, orthopedics, oncology, etc. Some healthcare plans require beneficiaries to obtain a referral from their primary care doctor before making an appointment to see a Specialist.

**Subscriber** - Medical billing term to describe the employee for group policies. For individual policies the subscriber describes the policyholder.

**Superbill** - One of the medical billing terms for the form the provider uses to document the treatment and diagnosis for a patient visit. Typically includes several commonly used ICD-10 diagnosis and CPT procedural codes. One of the most frequently used medical billing terms.

**Supplemental Insurance** - Additional insurance policy that covers claims for deductibles and coinsurance. Frequently used to cover these expenses not covered by Medicare.

**TAR** - Treatment Authorization Request. An authorization number given by insurance companies prior to treatment in order to receive payment for services rendered.

**Taxonomy Code** - Specialty standard codes used to indicate a provider's specialty sometimes required to process a claim.

**Term (Termination) Date** - Date the insurance contract expired or the date a subscriber or dependent ceases to be eligible.

**Tertiary Insurance Claim** - Claim for insurance coverage paid in addition to primary and secondary insurance. Tertiary insurance covers gaps in coverage the primary and secondary insurance may not cover.

**Third Party Administrator (TPA)** - An independent corporate entity or person (third party) who administers group benefits, claims and administration for a self-insured company or group.

**TIN** - Tax Identification Number. Also known as Employer Identification Number (EIN).

**TOP** - Triple Option Plan. An insurance plan which offers the enrolled a choice of a more traditional plan, an HMO, or a PPO. This is also commonly referred to as a cafeteria plan.

**TOS** - Type of Service. Description of the category of service performed.

**TRICARE** - This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors. Formerly known as CHAMPUS.

**UB04** - Claim form for hospitals, clinics, or any provider billing for facility fees similar to CMS 1500. Replaces the UB92 form.

**Unbundling** - Submitting several CPT treatment codes when only one code is necessary.

**Untimely Submission** - Medical claim submitted after the time frame allowed by the insurance payer. Claims submitted after this date are denied.

**Upcoding** - An illegal practice of assigning a diagnosis code that does not agree with the patient records for the purpose of increasing the reimbursement from the insurance payer.

**UPIN** - Unique Physician Identification Number. 6-digit physician identification number created by CMS. Discontinued in 2007 and replaced by NPI number.

**Utilization Limit** - The limits that Medicare sets on how many times certain services can be provided within a year. The patients claim can be denied if the services exceed this limit.

**Utilization Review (UR)** - Review or audit conducted to reduce unnecessary inpatient or outpatient medical services or procedures.

**V-Codes** - ICD-9-CM coding classification to identify health care for reasons other than injury or illness.

**Workers Comp** - Insurance claim that results from a work related injury or illness.

**Write-off** - Typically reference to the difference between what the physician charges and what the insurance plan contractually allows and the patient is not responsible for. May also be referred to as "not covered" in some glossary of billing terms.

## 11.6 KALHD Billing List-Serve & Regional Billing Groups

*KALHD Billing List-Serve*

The list serve that KALHD moderates is a state-wide forum for billers to ask questions and receive assistance from one another. No question is too simple or too complex. Billers on the list-serve range from first time billers to those with more than 20 years of experience. If you are not on the list serve but would like to be, simply send an email with your name, title, and county to billing@lists.kalhd.org with a request to join.

Please remember when using the list serve, every email and every reply will go to the whole group. Please keep questions and answers direct and to the point. Please do not reply to the whole group with pleasantries or email unrequested answers. This is not meant to be a deterrent in participation, but for you to be considerate of the amount of emails that we all must manage daily.

*Regional Billing Groups*

Regional Billing Groups are designed to help billers connect to one another through regular in-person meetings. MCO and payer reps can and should be invited to these meetings as well as other organizations and representatives who might be able to assist billers. These are self-run groups who will only continue if participation remains valid. Check with your regional rep below if you would like to receive invitations to these groups.

North Central Region (Billing Biddies)
Contact: Lenora Henderson, Ellsworth County, lhenders@eaglecom.net 785-472-4488

Northeast Region (Perpetually Perplexed Pros)
Contact(s): Kathy Ortega, Shawnee County, Kathy.ortega@snco.us 785-251-5662; OR
Melinda McIntyre, Johnson County, Melinda.McIntyre@jocogov.org 913-477-8352

Northwest Region (Billers Anonymous)
Contact: Kathy Eilert, Gove County, k.eilert@gchd.onmicrosoft.com 785-938-2335

South Central Region (Mission Impossible)
Contact: Jana Thimesch, Kingman County, jthimesch@kingmancoks.org 620-532-2221

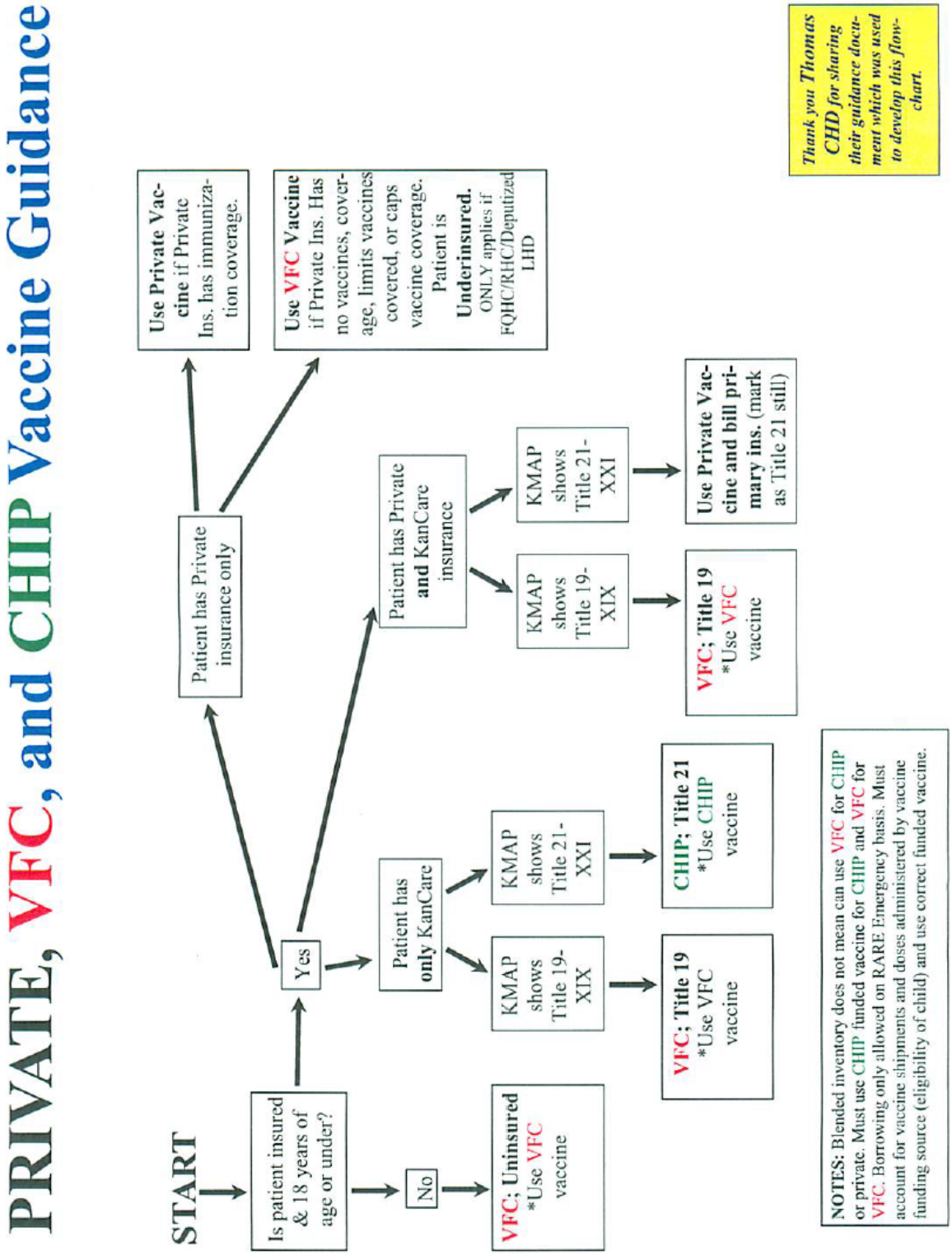
Southeast Region (Billers 'R' Us)
Contact: No current meetings or contact

Southwest Region (KIPHS User Group)
Contact: Michelle Miller, Haskell County, mmiller@satantahospital.org 650-675-8191

## 11.7 State LHD Map

Updated Map: http://www.kdheks.gov/olrh/download/PublicHealthRegionalAttendanceMap.pdf

## 11.8 Vaccine Guidance (Private, VFC and CHIP)



## 11.9 Common EDI Payer ID's

There are multiple options for EDI in Kansas, including ASK, Availity, KMAP, and individual insurance provider websites. A large collection of EDI payer codes is available from ASK at http://www.ask-edi.com/edi/edi_midwest_docs.htm.

| Insurance Company Name | ID | ERA | Notes |
|---|---|---|---|
| WPS (Medicare B) | 05202 | Y | |
| Palmetto GBA (Railroad Medicare B) | MR108 | Y | (888) 355-9165. EDI enrollment form listed under Payer Enrollment Forms - All or Multiple States. ERA activation can be found within the EDI enrollment form. |
| Aetna | 60054 | Y | Customer Service: (888) 632-3862.<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Amerigroup RealSolutions | 28804 | Y | |
| Amerigroup RealSolutions - KANCARE | 27514 | N | Coverage: Texas and Kansas. Customer Service: (800) 454-3730 |
| Assurant Health | 58730 | N | Customer Service: (888) 632-3862 |
| Benefit Management of Kansas | 48611 | | |
| BlueCross BlueShield of Kansas | 47163 | | Customer Service: (800) 432-3990 |
| BlueCross BlueShield of Nebraska | 00076 | Y | Customer Service: (888) 592-8961<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Champus | 99726 | | Customer Service: (877) 988-9378. Coverage: KS, NE.<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Champva | 99726 | | |
| Cigna | 62308 | Y | Customer Service: (800) 468-3510<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Corporate Benefit Services of America | 41124 | N | Now known as Meritain. Payer ID valid only for claims with a billing submission address of P.O. Box 27267, Minneapolis, MN 55427-0267 |
| Coventry Health Care | 25133 | Y | Coverage: KS, Customer Service: (301) 581-0600<br>Pre-Enrollment is required for Electronic Remittance Advice . |
| Delta Dental of Kansas | CDKS1 | | |
| First Health Network | 73159 | N | |
| Harrington Health | 62061 | | |
| Humana | 61101 | Y | Customer Service: (800) 448-6262<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| Medicare of Kansas J5 Part A – UB | 05201 | | |
| Medicaid of Kansas – J5 | 05202 | | |
| Meritain | 41124 | N | SEE Corporate Benefit Services of America. |
| National Telecommunications (NCTA) | 52103 | N | |
| Reserve National | 73066 | N | |
| Sunflower State Health Plan - KANCARE | 68069 | Y | Customer Service: (866) 595-8133<br>ERA enrollment forms will be listed under Centene Corporation. |
| The Benefit Group | 88051 | N | |
| Tricare For Life | TDDIR | Y | |
| Tricare West Region | 99726 | Y | Customer Service: (877) 988-9378<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| UMR | 39026 | Y | Customer Service: (877) 233-1800<br>Pre-Enrollment is required for Electronic Remittance Advice |
| United Healthcare | 87726 | Y | Customer Service: (866) 633-2446<br>Pre-Enrollment is required for Electronic Remittance Advice. |
| United Healthcare Community Plan of Kansas - KANCARE | 96385 | Y | Pre-Enrollment is required for Electronic Remittance Advice. |

## 11.10 Claim Examples: Medicare, Flu Shot (High Dose)

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

**HEALTH INSURANCE CLAIM FORM**

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

PICA

| | |
|---|---|
| 1. MEDICARE X (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): 123456789A |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JERRY L. | 3. PATIENT'S BIRTH DATE MM DD YY: 03 01 1945 SEX M X F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME |
| 5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN | 6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other | 7. INSURED'S ADDRESS (No., Street): |
| CITY: TOPEKA STATE: KS | 8. RESERVED FOR NUCC USE | CITY STATE |
| ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000 | | 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 X NO | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? YES X NO PLACE (State) | b. OTHER CLAIM ID (Designated by NUCC) |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES X 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 X 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: SIGNATURE ON FILE DATE: 08/01/2016

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: SIGNATURE ON FILE

| | |
|---|---|
| 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): 321586 | 20. OUTSIDE LAB? YES NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) ICD Ind. 0<br>A. Z23 B. C. D. E. F. G. H. I. J. K. L. | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>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 | 08 01 16 | 08 01 16 | 60 | | 90662 | | A | 30 00 | 1 | | NPI | 1234567890 |
| 2 | 08 01 16 | 08 01 16 | 60 | | G0008 | | A | 20 00 | 1 | | NPI | 1234567890 |
| 3 | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

| | | | | |
|---|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER: 481234567 SSN EIN X | 26. PATIENT'S ACCOUNT NO.: 12345 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO | 28. TOTAL CHARGE: $ 50 00 | 29. AMOUNT PAID: $ 0 00 | 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.)<br>SIGNATURE ON FILE 08/01/2016<br>SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | 33. BILLING PROVIDER INFO & PH #: ( 785 ) 291-0000<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 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

# Medicare, Pneumonia Shot (Prevnar 13)

**HEALTH INSURANCE CLAIM FORM**

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

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

PICA

| | |
|---|---|
| 1. MEDICARE [X] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ] | 1a. INSURED'S I.D. NUMBER: 123456789A |
| 2. PATIENT'S NAME: SMITH, JERRY L. | 3. PATIENT'S BIRTH DATE: 03 01 1945 SEX M [X] F [ ] |
| 4. INSURED'S NAME: SAME | |
| 5. PATIENT'S ADDRESS: 123 N. MAIN | 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ] |
| 7. INSURED'S ADDRESS | |
| CITY: TOPEKA STATE: KS | 8. RESERVED FOR NUCC USE |
| CITY STATE | |
| ZIP CODE: 66612 TELEPHONE: (785) 296-0000 | |
| ZIP CODE TELEPHONE: ( ) | |
| 9. OTHER INSURED'S NAME | 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 [X] |
| a. INSURED'S DATE OF BIRTH SEX M [ ] F [ ] | |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State) |
| b. OTHER CLAIM ID (Designated by NUCC) | |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES [ ] NO [X] |
| 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 [X] 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: SIGNATURE ON FILE DATE: 08/01/2016

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: SIGNATURE ON FILE

| | |
|---|---|
| 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): 319678 | 20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0<br>A. Z23 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 | 08 01 16 | 08 01 16 | 60 | | 90670 | | A | 152 00 | 1 | | NPI | 1234567890 |
| 2 | 08 01 16 | 08 01 16 | 60 | | G0009 | | A | 20 00 | 1 | | NPI | 1234567890 |
| 3 | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

| | | | | |
|---|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER: 481234567 SSN [ ] EIN [X] | 26. PATIENT'S ACCOUNT NO.: 12345 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ] | 28. TOTAL CHARGE: $ 172 00 | 29. AMOUNT PAID: $ 0 00 | 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.)<br>SIGNATURE ON FILE 08/01/2016<br>SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | | 33. BILLING PROVIDER INFO & PH #: ( 785 ) 291-0000<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 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

# Medicare, Flu Shot (High Dose) and Pneumonia Shot (Prevnar 13)

WPS GHA
Claims Department
P.O. Box 7238
Madison, WI 53707-7238

**HEALTH INSURANCE CLAIM FORM**

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

PICA

| | |
|---|---|
| 1. MEDICARE [X] (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): 123456789A |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JERRY L. | 3. PATIENT'S BIRTH DATE MM DD YY: 03 01 1945 SEX M [X] F [ ] |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME | |
| 5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN | 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ] |
| 7. INSURED'S ADDRESS (No., Street): | |
| CITY: TOPEKA STATE: KS | 8. RESERVED FOR NUCC USE |
| CITY: STATE: | |
| ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000 | |
| 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 [X] |
| a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ] | |
| b. RESERVED FOR NUCC USE: | b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State): |
| b. OTHER CLAIM ID (Designated by NUCC): | |
| c. RESERVED FOR NUCC USE: | c. OTHER ACCIDENT? YES [ ] NO [X] |
| 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 [X] 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: SIGNATURE ON FILE DATE: 08/01/2016

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: SIGNATURE ON FILE

| | |
|---|---|
| 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): 319677 | 20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0<br>A. Z23 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 | 08 01 16 | 08 01 16 | 60 | | 90662 | | A | 30 00 | 1 | | NPI | 1234567890 |
| 2 | 08 01 16 | 08 01 16 | 60 | | 90670 | | A | 152 00 | 1 | | NPI | 1234567890 |
| 3 | 08 01 16 | 08 01 16 | 60 | | G0008 | | A | 20 00 | 1 | | NPI | 1234567890 |
| 4 | 08 01 16 | 08 01 16 | 60 | | G0009 | | A | 20 00 | 1 | | NPI | 1234567890 |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

| | | | | |
|---|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER: 481234567 SSN [ ] EIN [X] | 26. PATIENT'S ACCOUNT NO.: 12345 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ] | 28. TOTAL CHARGE: $ 222 00 | 29. AMOUNT PAID: $ 0 00 |
| 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.)<br>SIGNATURE ON FILE 08/01/2016<br>SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | | 33. BILLING PROVIDER INFO & PH #: (785) 291-0000<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | |

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

## VFC, Multiple Vaccines

AMERIGROUP
PO BOX 65199
ATTN: CLAIMS CORRESPONDENCE
VIRGINIA BEACH, VA 23466

**HEALTH INSURANCE CLAIM FORM**

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

PICA

| | |
|---|---|
| 1. MEDICARE [X] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ] | 1a. INSURED'S I.D. NUMBER: 123456789A |
| 2. PATIENT'S NAME: SMITH, JERRY C. | 3. PATIENT'S BIRTH DATE: 05 26 2016 SEX: M [X] F [ ] |
| 4. INSURED'S NAME: SAME | |
| 5. PATIENT'S ADDRESS: 123 N. MAIN | 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ] |
| 7. INSURED'S ADDRESS | |
| CITY: TOPEKA STATE: KS | 8. RESERVED FOR NUCC USE |
| CITY STATE | |
| ZIP CODE: 66612 TELEPHONE: (785) 296-0000 | |
| ZIP CODE TELEPHONE: ( ) | |
| 9. OTHER INSURED'S NAME | 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 [X] |
| a. INSURED'S DATE OF BIRTH SEX | |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X] |
| b. OTHER CLAIM ID (Designated by NUCC) | |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES [ ] NO [X] |
| 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 [X] 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: SIGNATURE ON FILE DATE: 08/01/2016

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: SIGNATURE ON FILE

| | |
|---|---|
| 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): 83 | 20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) ICD Ind. 0<br>A. Z23 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 | 08 01 16 | 08 01 16 | 71 | | 90681 | | A | 000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 2 | 08 01 16 | 08 01 16 | 71 | | 90670 | | A | 000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 3 | 08 01 16 | 08 01 16 | 71 | | 90744 | | A | 000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 4 | 08 01 16 | 08 01 16 | 71 | | 90698 | | A | 000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 5 | 08 01 16 | 08 01 16 | 71 | | 90471 | | A | 2000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 6 | 08 01 16 | 08 01 16 | 71 | | 90472 | | A | 6000 | 3 | | 1D<br>NPI | 100000000A<br>1234567890 |

| | | | | |
|---|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER: 481234567 SSN [ ] EIN [X] | 26. PATIENT'S ACCOUNT NO.: 12890 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ] | 28. TOTAL CHARGE: $ 8000 | 29. AMOUNT PAID: $ 000 |
| 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.)<br>SIGNATURE ON FILE 08/01/2016<br>SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | 33. BILLING PROVIDER INFO & PH #: (785) 291-0000<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 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

## VFC, Flu Mist and HPV

AMERIGROUP
PO BOX 65199
ATTN: CLAIMS CORRESPONDENCE
VIRGINIA BEACH, VA 23466

**HEALTH INSURANCE CLAIM FORM**
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

| | |
|---|---|
| 1. MEDICARE [X] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ] | 1a. INSURED'S I.D. NUMBER: 123456789A |
| 2. PATIENT'S NAME: SMITH, JULIAN R. | 3. PATIENT'S BIRTH DATE: 07 13 2001 SEX: M [X] F [ ] |
| 4. INSURED'S NAME: SAME | |
| 5. PATIENT'S ADDRESS: 123 N. MAIN | 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ] |
| 7. INSURED'S ADDRESS | |
| CITY: TOPEKA STATE: KS | 8. RESERVED FOR NUCC USE |
| CITY STATE | |
| ZIP CODE: 66612 TELEPHONE: (785) 296-0000 | |
| ZIP CODE TELEPHONE: ( ) | |
| 9. OTHER INSURED'S NAME | 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 [X] |
| a. INSURED'S DATE OF BIRTH SEX | |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X] |
| b. OTHER CLAIM ID (Designated by NUCC) | |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES [ ] NO [X] |
| 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 [X] 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: SIGNATURE ON FILE DATE: 08/01/2016

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: SIGNATURE ON FILE

| | |
|---|---|
| 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): 54 | 20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) ICD Ind. 0<br>A. Z23 B. C. D. E. F. G. H. I. J. K. L. | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>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 | 08 01 16 | 08 01 16 | 71 | | 90675 | | A | 000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 2 | 08 01 16 | 08 01 16 | 71 | | 90651 | | A | 000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 3 | 08 01 16 | 08 01 16 | 71 | | 90473 | | A | 2000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 4 | 08 01 16 | 08 01 16 | 71 | | 90472 | | A | 2000 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

| | | | | | |
|---|---|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER: 481234567 SSN [ ] EIN [X] | 26. PATIENT'S ACCOUNT NO.: 12789 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ] | 28. TOTAL CHARGE: $ 4000 | 29. AMOUNT PAID: $ 000 | 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.)<br>SIGNATURE ON FILE 08/01/2016<br>SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | | 33. BILLING PROVIDER INFO & PH #: (785) 291-0000<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | | |

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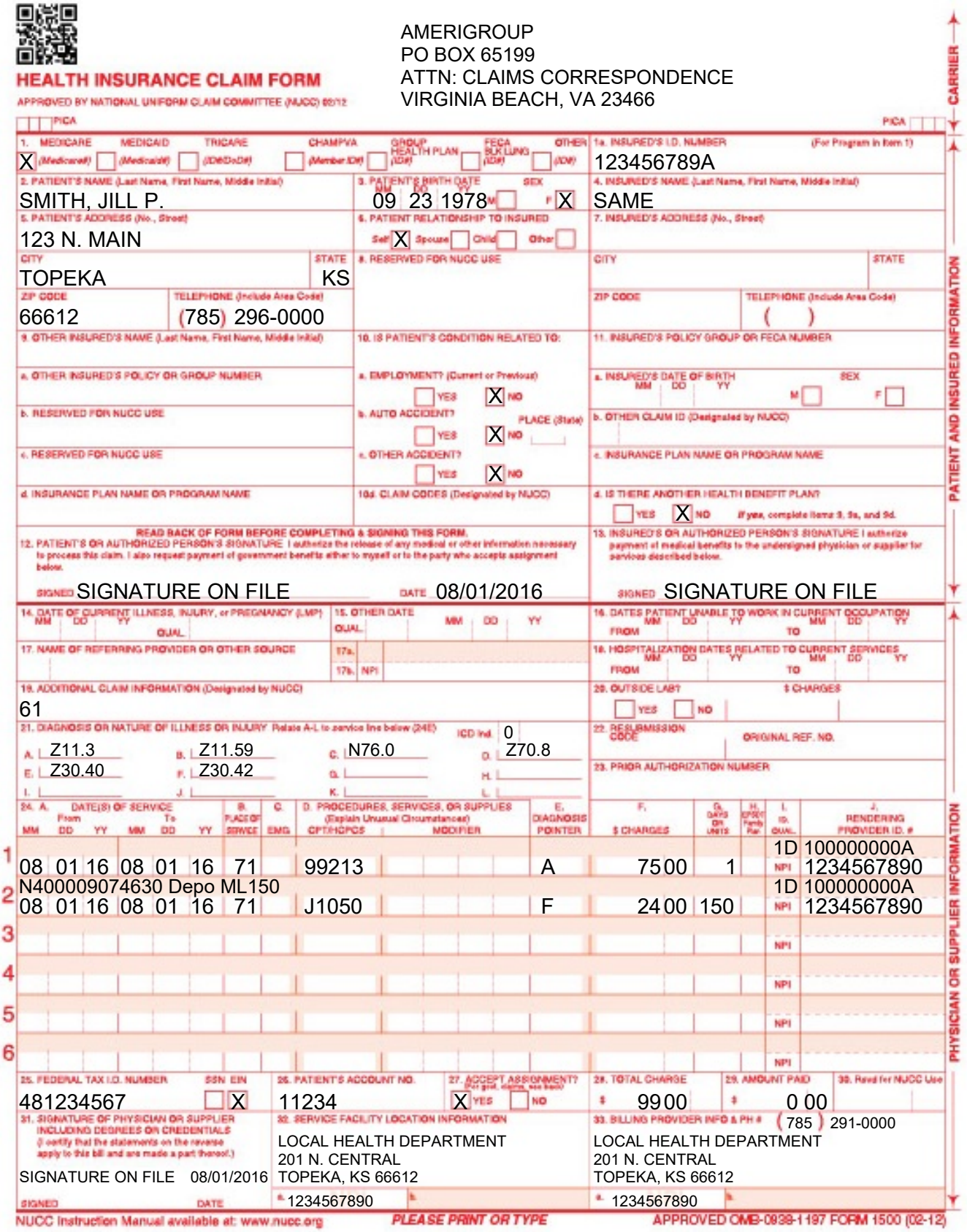
CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

## STD and Depo



HEALTH INSURANCE CLAIM FORM

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

AMERIGROUP
PO BOX 65199
ATTN: CLAIMS CORRESPONDENCE
VIRGINIA BEACH, VA 23466

PICA

1. MEDICARE X (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): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JILL P.

3. PATIENT'S BIRTH DATE MM DD YY: 09 23 1978 | SEX M ( ) F X

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

5. PATIENT'S ADDRESS (No., Street): 123 N. MAIN

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse ( ) | Child ( ) | Other ( )

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

CITY: TOPEKA | STATE: KS

8. RESERVED FOR NUCC USE

CITY: | STATE:

ZIP CODE: 66612 | TELEPHONE (Include Area Code): (785) 296-0000

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 X

a. INSURED'S DATE OF BIRTH MM DD YY: | SEX M ( ) F ( )

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES ( ) NO X PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES ( ) NO X

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 X 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 SIGNATURE ON FILE DATE 08/01/2016

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 SIGNATURE ON FILE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 61

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z11.3 B. Z11.59 C. N76.0 D. Z70.8
E. Z30.40 F. Z30.42 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 08 01 16 | 08 01 16 | 71 | | 99213 | | A | 75 00 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 2 N400009074630 Depo ML150 | | | | | | | | | | 1D | 100000000A |
| 2 08 01 16 | 08 01 16 | 71 | | J1050 | | F | 24 00 | 150 | | NPI | 1234567890 |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 481234567 | SSN ( ) EIN X

26. PATIENT'S ACCOUNT NO.: 11234

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

28. TOTAL CHARGE: $ 99 00

29. AMOUNT PAID: $ 0 00

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.)

SIGNATURE ON FILE 08/01/2016
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # ( 785 ) 291-0000

LOCAL HEALTH DEPARTMENT
201 N. CENTRAL
TOPEKA, KS 66612

a. 1234567890 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

## Exam and Depo

AMERIGROUP
PO BOX 65199
ATTN: CLAIMS CORRESPONDENCE
VIRGINIA BEACH, VA 23466

**HEALTH INSURANCE CLAIM FORM**

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

PICA

| | |
|---|---|
| 1. MEDICARE [X] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ] | 1a. INSURED'S I.D. NUMBER: 123456789A |
| 2. PATIENT'S NAME: SMITH, JILL P. | 3. PATIENT'S BIRTH DATE: 09 23 1978 SEX: M [ ] F [X] |
| 4. INSURED'S NAME: SAME | |
| 5. PATIENT'S ADDRESS: 123 N. MAIN | 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ] |
| 7. INSURED'S ADDRESS | |
| CITY: TOPEKA STATE: KS | 8. RESERVED FOR NUCC USE |
| CITY STATE | |
| ZIP CODE: 66612 TELEPHONE: (785) 296-0000 | |
| ZIP CODE TELEPHONE: ( ) | |
| 9. OTHER INSURED'S NAME | 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 [X] |
| a. INSURED'S DATE OF BIRTH SEX | |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X] |
| b. OTHER CLAIM ID (Designated by NUCC) | |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES [ ] NO [X] |
| 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 [X] 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: SIGNATURE ON FILE DATE: 08/01/2016

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: SIGNATURE ON FILE

| | |
|---|---|
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL. | 15. OTHER DATE QUAL. |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. 17b. NPI |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 73 | 20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0<br>A. Z01.419 B. Z11.3 C. Z71.9 D. Z11.59<br>E. Z30.42 F. G. H.<br>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 08 01 16 | 08 01 16 | 71 | | S0610 | | A | 120 00 | 1 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 2 N400009074630 Depo ML150<br>08 01 16 | 08 01 16 | 71 | | J1050 | | E | 24 00 | 150 | | 1D<br>NPI | 100000000A<br>1234567890 |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

| | | | | | |
|---|---|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER: 481234567 SSN [ ] EIN [X] | 26. PATIENT'S ACCOUNT NO.: 11234 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ] | 28. TOTAL CHARGE: $ 144 00 | 29. AMOUNT PAID: $ 0 00 | 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.)<br>SIGNATURE ON FILE 08/01/2016<br>SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | 33. BILLING PROVIDER INFO & PH #: ( 785 ) 291-0000<br>LOCAL HEALTH DEPARTMENT<br>201 N. CENTRAL<br>TOPEKA, KS 66612<br>a. 1234567890 b. | | | |

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

## 11.11 National Drug Code Conversion Table

A National Drug Code (NDC) has three segments:

- The first segment is 5 digits long and is assigned by the Food and Drug Administration (FDA) to identify the facility that manufactures, repacks or distributes the drug product.
- The second segment is 4 digits long and identifies a specific strength, dosage form, and formulation for a particular product.
- The third segment is 2 digits long and identifies package forms and sizes,

Proper billing requires an 11-digit number in the 5-4-2 format. The NDC may be displayed on the package in a 10-digit format. Converting the NDC from 10 to 11 digits requires adding a zero to the beginning of the segment that is too short. The following table shows where to add the zero. The example is shown in bold and underlined solely to illustrate the examples.

**Do not use hyphens when entering the actual data in your claim.**

| Converting NDCs from 10 to 11 digits. | | | | |
|---|---|---|---|---|
| 10-Digit Example | 11-Digit Example | Actual NDC Conversion | | Claim NDC |
| 9999 – 9999 – 99<br>4 – 4 – 2 | **0**9999 – 9999 – 99<br>5 – 4 – 2 | 0002-7597-01 | **0**0002-7597-01 | 00002759701 |
| 99999 – 999 – 99<br>5 – 3 – 2 | 99999 – **0**999 – 99<br>5 – 4 – 2 | 50242-040-62 | 50242-**0**040-62 | 50242004062 |
| 99999 – 9999 – 9<br>5 – 4 – 1 | 99999 –9999 – **0**9<br>5 – 4 – 2 | 60575-4112-1 | 60575-4112-**0**1 | 60575411201 |

# 11.12 Local Health Department Kan-Be-Healthy Billing Reference Tool

## KanCare Only (Updated February 1, 2019)

**Components 1, 2, 3, and 6**

| *Preventative* | | | | *Evaluation Management* | | |
|---|---|---|---|---|---|---|
| **Age (New Pt)** | **CPT Code** | **ICD-10 Code** | **Reimbursement** | **Service (New Pt)** | **CPT Code** | **Reimbursement** |
| 1 day-11 months | 99381 | Z00.121, Z00.129 | $70.00 | Problem Focused (10 min) | 99201 | $30.91 |
| 1 year-4 years | 99382 | Z00.121, Z00.129 | $70.00 | Expanded Problem Focused (20 min) | 99202 | $50.66 |
| 5 years-11 years | 99383 | Z00.121, Z00.129 | $70.00 | Detailed (30 min) | 99203 | $75.45 |
| 12 years-17 years | 99384 | Z00.121, Z00.129 | $70.00 | Comprehensive (45 min) | 99204 | $107.12 |
| 18 years-20 years | 99385 | Z00.00, Z00.01 | $70.00 | | | |
| | | | | Nurse Visit/Assessment (KanCare only, one use per member per lifetime per provider) | T1001 | $30.00 |
| **Age (Est. Pt)** | **CPT Code** | **ICD-10 Code** | **Reimbursement** | **Service (Est. Pt)** | **CPT Code** | **Reimbursement** |
| 1 day-11 months | 99391 | Z00.121, Z00.129 | $70.00 | Nurse Visit | 99211 | $16.36 |
| 1 year-4 years | 99392 | Z00.121, Z00.129 | $70.00 | Problem Focused | 99212 | $29.76 |
| 5 years-11 years | 99393 | Z00.121, Z00.129 | $70.00 | Expanded Problem Focused | 99213 | $40.84 |
| 12 years-17 years | 99394 | Z00.121, Z00.129 | $70.00 | Detailed | 99214 | $64.22 |
| 18 years-20 years | 99395 | Z00.00, Z00.01 | $70.00 | | | |

**If an illness or abnormality is encountered, or a preexisting problem is addressed, in the process of performing the preventive medicine service, and if the illness, abnormality, or problem is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management (E/M) service (history, physical examination, medical decision-making, or a combination of those), the appropriate office or other outpatient service code (99201–99215) should be reported in addition to the preventive medicine service code. Modifier 25 should be appended to the office or other outpatient service code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service.**

**Components 4 and 5**

| *Development and Nutrition* | | | |
|---|---|---|---|
| **Service** | **CPT Code** | **ICD-10-CM Code** | **Reimbursement** |
| Developmental Screening with interpretation and report | 96110 | Z00.121, Z00.129, Z00.00, Z00.01 | $31.50 |
| Brief emotional/behavioral assessment with scoring and documentation per standard instrument | 96127 | Z13.89 | $3.09 |
| Nutrition Assessment; initial assessment, each 15 mins | 97802 | Z71.3 | $21.20 |
| Nutrition Assessment; re-assessment, each 15 mins | 97803 | Z71.3 | $20.00 |

**Component 7**

## *Lead*

| Service | CPT Code | ICD-10-CM Code | Reimbursement |
|---|---|---|---|
| Lead Screen (in facility) | 83655 | Z13.88 (screen), Z77011 (exposure) | $11.70 |
| Venipuncture (sent to outside laboratory) | 36415 | | - |

**Component 8**

## *Laboratory*

| **Model 1: Blood is drawn in office and specimen is sent to an outside laboratory for analysis** | | | **Model 2: Blood is drawn and laboratory tests are performed in the physician's practice** | | |
|---|---|---|---|---|---|
| **Service** | **CPT Code** | **Reimbursement** | **Service** | **CPT Code** | **Reimbursement** |
| Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory | 99000 | Included in preventative/ E&M | Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture | 36406 | $13.63 |
| Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture | 36406 | $13.63 | Venipuncture, 3 years or older, necessitating physician's skill, for diagnostic or therapeutic purposes (not be used for routine venipuncture) | 36410 | $13.90 |
| | | | Collection of venous blood by venipuncture | 36415 | - |
| | | | Collection of capillary blood specimen (e.g., finger, heel, or ear stick) | 36416 | - |
| | | | Bilirubin, total | 85018 | $1.31 |
| Venipuncture, 3 years or older, necessitating physician's skill, not to be used for routine venipuncture | 36410 | $13.90 | Bilirubin, total, transcutaneous | 88720 | $6.25 |
| | | | Lipid panel (includes total cholesterol, high-density lipoprotein [HDL] cholesterol, and triglycerides) | 80061 | $15.12 |
| | | | Cholesterol, serum, total | 82465 | $6.01 |
| | | | Lipoprotein, direct measurement, high-density cholesterol (HDL) | 83718 | $11.25 |
| | | | Triglycerides | 84478 | $6.30 |
| | | | Blood count; hemoglobin | 85018 | $1.31 |

**Component 9**

## *Immunizations*

Please see appropriate immunization codes for immunizations.

**Component 10**

## *Audiology*

| Service | CPT Code | ICD-10 Code | Reimbursement |
|---|---|---|---|
| Hearing, pure tone, air only | 92551 | Z00.121, Z00.129, Z00.00, Z00.01 | $13.83 |
| Hearing, pure tone audiometry; air only | 92552 | Z00.121, Z00.129, Z00.00, Z00.01 | $15.28 |
| Hearing, pure tone audiometry; air and bone | 92553 | Z00.121, Z00.129, Z00.00, Z00.01 | $20.97 |
| Hearing, speech threshold | 92555 | Z00.121, Z00.129, Z00.00, Z00.01 | $11.94 |
| Hearing, comprehensive evaluation & speech recognition | 92557 | Z00.121, Z00.129, Z00.00, Z00.01 | $39.77 |
| Tympanometry (impedance testing) | 92567 | Z00.121, Z00.129, Z00.00, Z00.01 | $16.08 |
| Acoustic reflex testing, threshold | 92568 | Z00.121, Z00.129, Z00.00, Z00.01 | - |
| Conditioning play audiometry | 92582 | Z00.121, Z00.129, Z00.00, Z00.01 | - |
| Evoked response (EEG) audiometry | 92585 | Z00.121, Z00.129, Z00.00, Z00.01 | $75.23 |
| Automated Auditory Brainstem Response | 92586 | Z00.121, Z00.129, Z00.00, Z00.01 | - |
| Evoked Otoacoustic Emissions; limited | 92587 | Z00.121, Z00.129, Z00.00, Z00.01 | $44.67 |

**Components 11 and 12**

## *Dental and Vision*

| Service | CPT Code | ICD-10 Code | Reimbursement |
|---|---|---|---|
| Vision, bilateral | 99173 | Z00.121, Z00.129, Z00.00, Z00.01 | $5.00 |
| Topical Fluoride Varnish | D1206 | Z01.20, Z01.21 | - |
| Topical Application of Fluoride | D0120 | | - |

**All information listed here is for reference and suggestion only. Please review all requirements for service and documentation prior to utilizing any listed CPT or ICD-10 codes.**

Information for this reference tool can be found in the KBH Manual (https://kmap-state-ks.us/Documents/Content/Provider%20Manuals/KBH_10012018_18154.pdf) as well as the AAP Manual (https://www.aap.org/en-us/Documents/coding_preventive_care.pdf)..

All reimbursement rates listed are accurate as of February 1, 2019. To view current reimbursement rates:

1: Go to https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp through internet explorer.
2. Accept the terms and conditions
3. Enter the code in the CHPCS box
4. Choose "Title XIX" for the benefit plan
5. Chooses provider type 13
6. Choose provider specialty #131.