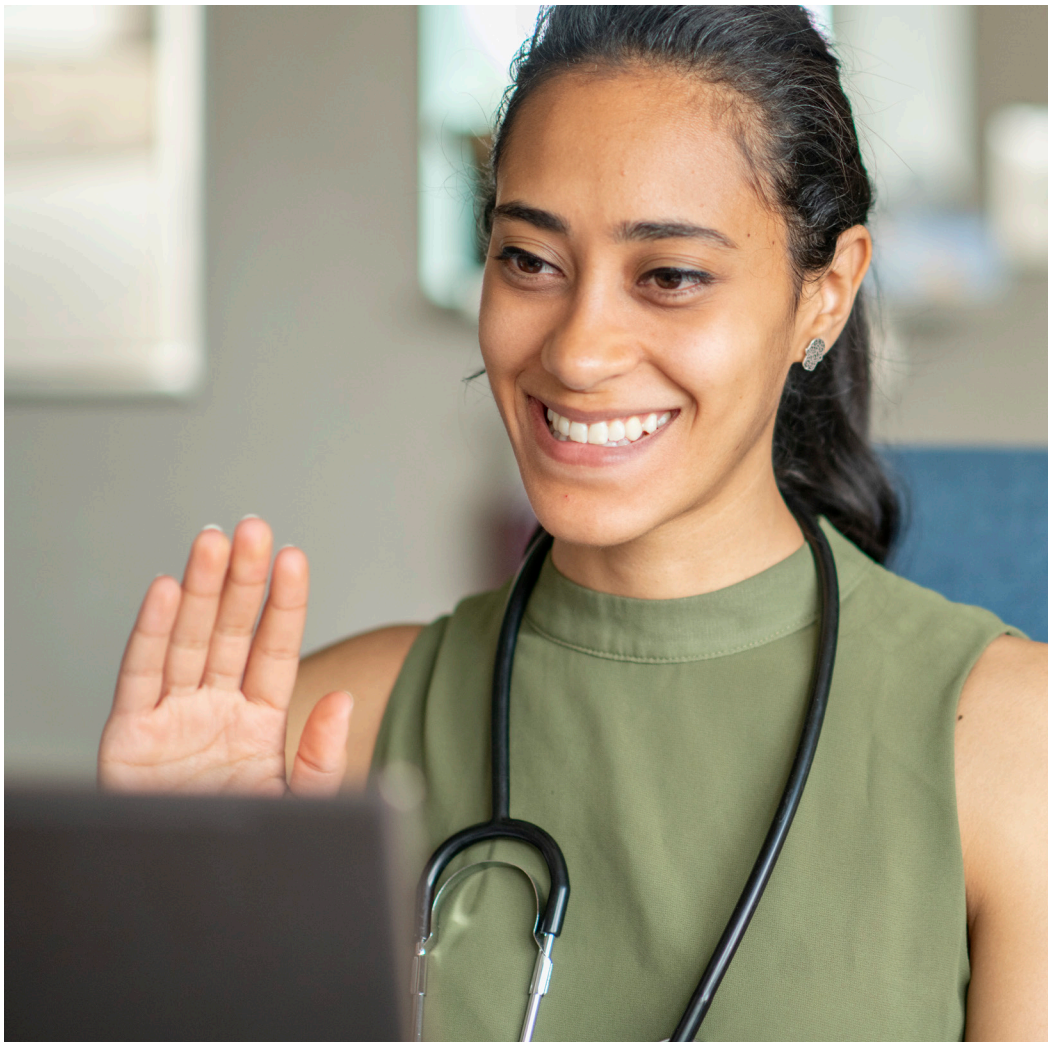
Healthy Blue Provider Billing Guide

Medicaid



Provider Services: 844-594-5072
https://provider.healthybluenc.com

BlueCross BlueShield of North Carolina | HealthyBlue®

NCHB-CD-005766-22

Blue Cross and Blue Shield of North Carolina

Healthy Blue Provider Billing Guide

Notes:

- Availity, LLC is an independent company providing administrative support services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.
- AIM Specialty Health is an independent company providing some utilization review services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.
- EyeMed is an independent company providing vision services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.
- ModivCare is an independent company providing transportation services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.
- CareBridge is an independent company providing electronic visit verification services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.
- Optum is an independent company providing telephonic tobacco cessation counseling services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.
- HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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About Us

Healthy Blue is a Medicaid plan offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC). Certain administrative services for Healthy Blue are provided by Amerigroup Partnership Plan, LLC pursuant to an administrative services agreement. References to Blue Cross NC may mean Blue Cross NC or their designee, Amerigroup Partnership Plan, LLC.

Please refer to the reimbursement policies on the Healthy Blue provider website, the Healthy Blue provider manual, and/or your provider contract as a guide for reimbursement(s). Reimbursement policies serve as a guide to assist in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan.

The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination of reimbursement. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry-standard compliant codes on all claim submissions.

Claim Submission and Adjudication Procedures

Availity Provider Essentials

Filing claims should be simple. Blue Cross NC uses Availity, a secure and full-service web portal that offers a claims clearinghouse and real-time transactions at no charge to Healthy Blue contracted providers. Providers can use Availity to submit and check the status of any and all claims.

Find these tools on Availity:

- Claims submission
- Claims status inquiry and claim dispute
- Clear Claims Connection™
- Authorizations
- Precertification lookup tool
- Eligibility and benefits inquiry
- Registration for provider online reporting
- Patient360

Claims submission

Claims can be submitted electronically or by mail. Electronic claims submission is preferred either through a clearinghouse or directly to the Healthy Blue Claims department through Availity.

Receive payments quickly by enrolling in electronic fund transfer (EFT) at **https://enrollsafe.payeehub.org**. Enrollment in EFT eliminates paper, saves money, and time.

Enrolling in EFT at the tax identification number (TIN) level is recommended, as all affiliated NPIs that bill under your TIN will be captured for payment.

Clearinghouse submission

Claims can be submitted electronically through electronic data interchange (EDI) by using a clearinghouse or using your practice management software. The clearinghouse must be able to connect to Availity and work directly with Availity to resolve any questions.

Claims must be submitted within 180 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services. Because of the importance of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings and the collection of data related to said services, it is encouraged to submit EPSDT claims as soon as possible within the timely filing period.

For more information about electronic transactions, call Availity Client Services at **1-800-AVAILITY (1-800-282-4548)** from 8 a.m. to 8 p.m. Eastern time, Monday through Friday.

Availity Provider Essentials claim submission

Submit single claims on the Availity website by:

- Navigating to the **Availity Essentials** website and logging in with your username and password.
- From the Availity home page, choosing **Claims & Payments** from the top navigation.
- Selecting the desired **Claim Type** from the drop-down menu.
- Entering claims online using data entry screens similar to the *CMS-1500* or *UB-04* claim template forms.
- Uploading a *HIPAA*-compliant ANSI 837 5010 claim transaction.

Use the **Availity Essentials** for single claim filing, claim status inquiries, verifying member eligibility and benefits information.

Availity Essential customer support can be contacted by phone at **1-800-AVAILITY (1-800-282-4548)** Monday through Friday, 8 a.m. to 7:30 p.m. Eastern time.

Timely filing

Blue Cross NC allows a total of 180 days for the submission of a clean and/or corrected claim. Timely filing is determined by subtracting the date of service from the date Blue Cross NC receives the claim and comparing the number of days to the applicable timely filing limit of 180 days.

If services are rendered on consecutive days, such as a hospital confinement, the limit will be counted from the last day of admission. Limits are based on calendar days unless otherwise specified. If the member has other health insurance that is primary, then the timely filing is counted from the date the *Explanation of Payment (EOP)* of the other carrier.

Claims filed beyond timely filing limits will be denied due to the claims being received outside the timely filing limit. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit or demonstrating good cause for filing outside of the timely period. Please refer to the Healthy Blue **Proof of Timely Filing** policy, for additional guidance.

Paper claims submission

Paper claims must be completed by using a *UB-04* or *CMS-1500 (08-05)* claim form. The form must be submitted within 180 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening claims should be filed as soon as possible within the timely filing period:

- On the original claim form with drop-out red ink
- Computer-printed or typed
- In a large, dark font

Please submit paper claims to:

Blue Cross NC | Healthy Blue
Claims Department
P.O. Box 61010
Virginia Beach, VA 23466

There are exceptions to the timely filing requirements, for example, in cases of coordination of benefits/subrogation. The time frame for filing a claim will begin on the date of the primary carrier's *Explanation of Benefits* or 365 days from the date of discharge for inpatient services. As a reminder, the following information applies to administrative retroactive correction claims:

- Claims must be submitted via paper/hard copy.
- A copy of the voided *Explanation of Payment* is required for documentation purposes.
- Claims received more than six months after the date the claim is voided will be denied for untimely filing.
- For more information on the Healthy Blue coordination of benefits, reference the *Other Health Insurance* bulletin on the Healthy Blue provider website.

Note: Please refer to the Healthy Blue **Proof of Timely Filing** policy, for additional guidance on Good Cause.

Claims submission quality expectations

- Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for Compliance SNIP levels 1 to 4.
- Professional claims that meet standardized X12 EDI Transaction Standard: 837P — Professional Claims
- Institutional claims that meet standardized X12 EDI Transaction Standard: 837I — Institutional Claims

Availity will return response reports after all claim submissions detailing and advising if any errors require resubmission.

Claim submissions, whether electronic or paper, must include the following information:

- Member's subscriber ID number, including alpha prefix
- Member's name
- Member's date of birth
- ICD-10-CM diagnosis code
- Date of service
- Place of service
- Procedures, services, or supplies rendered with CPT-4 codes/HCPCS codes/disease-related groups
- Itemized charges

- Days or units
- Provider tax ID number
- Provider name according to contract
- Billing provider information, and rendering provider information when different than billing or when billing a group taxonomy
- NPI of billing and rendering provider when applicable, or API when NPI is not appropriate
- Taxonomy of billing provider, attending, and rendering provider when submitted
- Coordination of benefits/other insurance information
- Precertification number or copy of precertification
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- Any other state-required data (see **Appendix B**)

Provider and member data will be verified against North Carolina Department of Health and Human Services' (NC DHHS) data for accuracy, status and eligibility for both the provider and member. Be sure to validate all data in advance of claims submission(s). This validation will apply to all provider data submitted including atypical and out-of-state providers.

National Drug Code (NDC) data will be validated for appropriate use for service rendered as well as confirming the NDC is effective on the date of service.

The *Patient Protection and Affordable Care Act* (H.R. 3590 Section 65607 Mandatory State Use of National Correct Coding Initiative (NCCI)) requires state Medicaid programs to incorporate NCCI methodologies into their claims processing systems. The purpose of the NCCI edits is to prevent improper payments when incorrect code combinations are reported. The two components of NCCI are procedure-to-procedure edits (CCI) and medically unlikely edits (MUE).

- CCI procedure-to-procedure edits are for practitioners, ambulatory surgical centers, and outpatient hospital services (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level) that define pairs of HCPCS/CPT codes that should not be reported together.
- MUE are units of service edits for practitioners, ambulatory surgical centers, outpatient hospital services (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level) and durable medical equipment (DME). This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct (for example, claims for excision of more than one appendix or more than one hysterectomy).

Providers are reminded that:

- Services must be reported correctly.
- Multiple HCPCS/CPT codes should not be reported when there is a single comprehensive HCPCS/CPT code.

- The code describes these services.
- A procedure should not be fragmented into component parts.
- A bilateral procedure code should not be unbundled into two unilateral procedure codes.
- Down-coding and up-coding should be avoided.
- The appropriate procedure codes should be used based on the age and gender of the patient.
- If a procedure code is submitted that requires a primary procedure code, verify that the primary procedure code has been submitted.
- Procedure codes are billed in the appropriate place of service as defined by American Medical Association (AMA) and/or Centers for Medicare & Medicaid Services (CMS) (for example, certain procedure codes are not permitted to be performed outside of an inpatient setting).
- Obstetric services including antepartum care, delivery, and postpartum care are billed appropriately.
- The appropriate evaluation and management (E&M) codes are used for new patients and established patients.
- Certain services related to surgical procedures are included in the payment of the global surgery package. These services would include E&M and related surgical procedures performed by the same physician for the same patient.
- Duplicate services are not submitted for the same provider or same patient for the same date of service.
- Consent forms are required for the following services: abortion, hysterectomy, and sterilization.
- Providers must submit both the national DME miscellaneous and corresponding Local W codes on claims. Local codes should be noted in the service description, as they will fail the National Uniform Billing Committee service validations if used as the principal service. If the specified local W codes are not on the claim, the claim(s) will be denied.
- Newborns must have their assigned Medicaid ID and Healthy Blue ID before the provider can bill for services.
- Newborn claims cannot be billed under the mother following the delivery.
- Hospitals are required to follow the requirements for reporting and reimbursing for hospital acquired conditions.

Claims Attachments

Blue Cross NC accepts Healthy Blue electronic claim attachments via the secure Availity Provider Essentials or an electronic data interchange (EDI) 275 (Medical Attachments) transaction.

Guidance on completing the EDI 275 transaction can be found at:

Healthy Blue provider website
Availity EDI companion guide
Availity EDI 275 companion guide

To submit an attachment using Availity Essentials, locate the specific claim in which documentation needs to be sent and then select send attachment and upload the document.

Common Denial Reasons

Claims submitted after the timely filing limit: Denial reason code **TFO** indicates the claim was submitted after the claim filing limit. A properly completed *UB-04* or *CMS-1500 (08-05)* claim submitted within 180 calendar days from the date of discharge for inpatient services, or from the date of service for outpatient services. Also, consider Other Health Insurance (OHI) time limit filing, which begins with the date of the disposition of the primary insurer's *Explanation of Benefit*.

Disallow-not allowed under the provider's contract: Denial reason code **G18** indicates various reasons, such as provider data issue, contract agreement issues, and/or no rate on the fee schedule.

Serum available at No Cost Through Vaccines for Children (VFC): Denial reason code **GBH** indicates the serum is available at no cost through VFC. Blue Cross NC allows for reimbursement of the administration fee for vaccines provided by the VFC. The serum code(s) must be included on the claim to meet regulatory and Healthcare Effective Data Information Set (HEDIS®) reporting requirements.

Definite Duplicate Claim: Denial reason code **CDD** indicates the specified claim is a duplicate of a previously submitted claim. The provider should review previous *Explanation of Payment (EOP)* to identify the impacted claim.

Not a Covered Service: Denial reason code **PS0** indicates the service listed on the claim is not covered under the member's benefit plan.

PEGA-EOB Required from Primary Carrier: Denial reason code **QA0** indicates the *Explanation of Benefits* is needed from the member's primary carrier. Providers can use the claim attachment functionality in Availity to attach the primary carrier to the claim.

Incidental to a Current Procedure: Denial reason code **e27** indicates submitted procedure is disallowed and is incidental to another procedure.

Not Separately reimbursable: Denial reason code **YF9** indicates the code(s) listed on the claim is not separately reimbursable.

Deny Preauth Not Obtained: Denial reason code **Y3Z** indicates an authorization is required for the code listed on the claim.

No Medicaid # and/or Disclosure Form: Denial reason code **G72** indicates the provider is not enrolled in Medicaid (not active in NCTracks on date of service).

Providers are encouraged to review the **Known Issues Bulletin** for information related to issues impacting Healthy Blue providers. The Known Issue Bulletin is updated weekly.

Please contact Healthy Blue Provider Services at **844-594-5072** or your dedicated Healthy Blue representative if there are any questions related to the issues listed on the Known Issue Bulletin.

Common Overpayment Reasons

Anesthesia Modifier AA: Indicates the anesthesiology service was performed personally by an anesthesiologist. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate.

Note: Reference the **Professional Anesthesia Services** reimbursement policy for additional information.

Duplicate Professional/Independent Lab Claims: Blue Cross NC does not allow separate reimbursement for specimen validity testing when utilized for drug screening. Specimen validity testing is included in the presumptive and definitive drug testing CPT and HCPCS code descriptions. Modifiers will override this edit.

Note: Reference the **Drug Screen Testing** reimbursement policy for more information.

Global OB (Obstetrics) Procedures Overpayments: Occurs when a physician bills individual visits, specific laboratory, and diagnostic services along with a global delivery code (59400, 59410, 59510, 59515, 59610, 59614, 59618 and 59622). The services provided for a pregnancy related diagnosis that are performed 279 days prior to and 45 days after the delivery are included in the global delivery reimbursement.

Note: Global maternity services include antepartum (prenatal) and/or postpartum care. Reference the **Maternity Services** reimbursement policy for more information.

Initial vs. Subsequent E/M (Evaluation/Management) Codes Overpayments: Blue Cross NC allows reimbursement of a duplicate or subsequent service provided on the same date of service if billed with an appropriate modifier or with additional units unless, as applicable within benefit limits, otherwise noted by provider, state, federal or CMS contracts and/or requirements.

Note: Reference the **Subsequent Services on the Same Date of Service** reimbursement policy for more information.

Multiple Surgery Reduction Professional: Professional provider claims for applicable surgical procedures must be billed with Modifier 51 to denote a multiple procedure. Facility claims should not be billed with Modifier 51. However, the following reductions apply to both physician and facility claims.

Note: Multiple surgery reduction only applies to Professional Claims, pays according to the fee schedule and/or the contracted/negotiated rate, then 50% for each additional procedure.

Billing Members

Prior to rendering a service that is not covered by Blue Cross NC, members must be informed that the service(s) to be rendered are not covered by North Carolina Medicaid and he or she will have to pay for the service. If you choose to provide services that we do not cover:

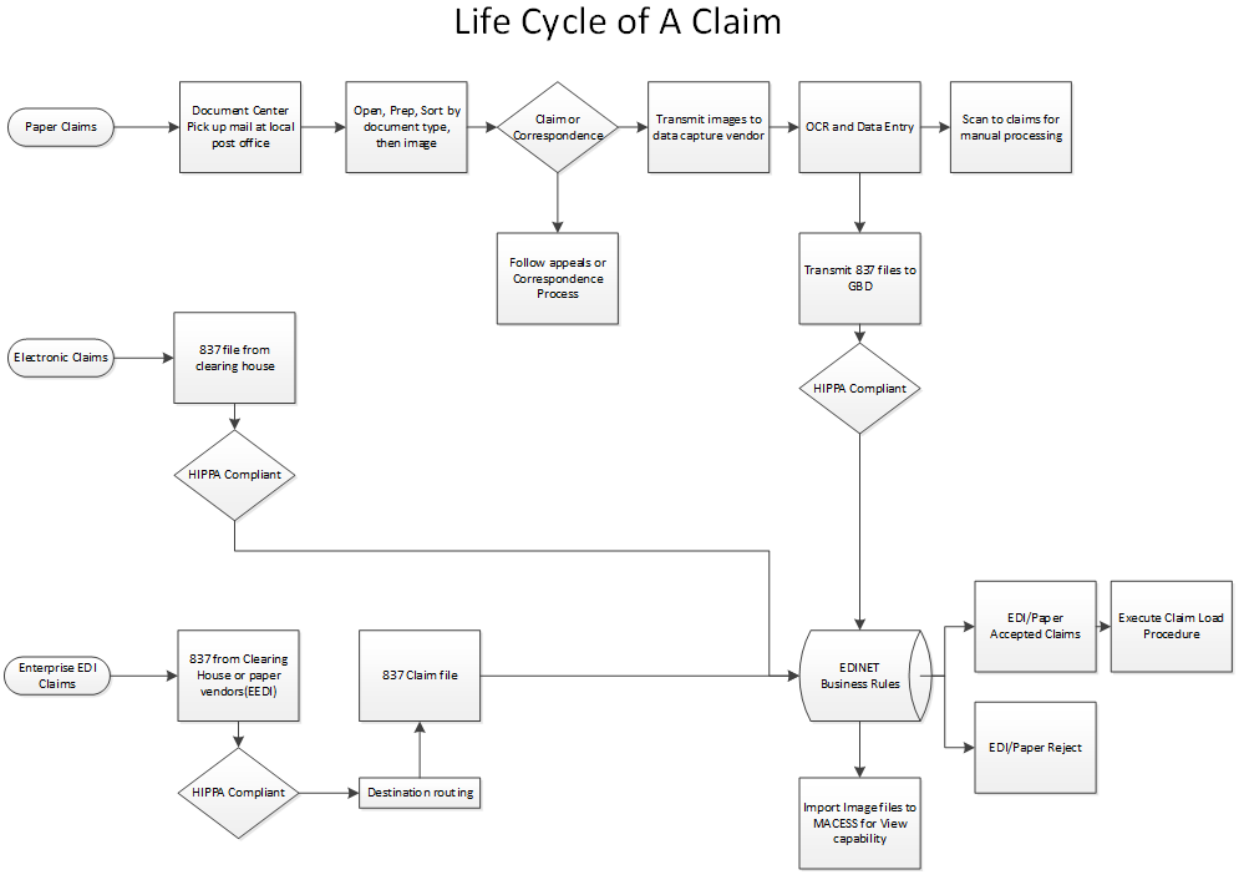
- Understand that reimbursement is only for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the *Client Acknowledgment Statement* specifying that the member will be held responsible for payment of services.
- Understand that you may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the Medicaid program.

Medicaid members cannot be balance-billed for the amount above the contracted/negotiated rate of reimbursement. In addition, Medicaid members cannot be billed for any of the following reasons:

- Failure to submit a claim on time, including claims not received by Blue Cross NC.
- Failure to submit a claim to Blue Cross NC for initial processing within the timely filing deadline for providers.
- Failure to dispute a corrected claim within the clean-claim submission period.
- Failure to appeal a claim within the 90-day payment dispute period.
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial.
- Submission of an unsigned or otherwise incomplete claim.
- Errors made by the provider in claims preparation, claims submission or the appeal/dispute process.

Life Cycle of a Claim

The image below outlines the life cycle of a claim when submitted to Blue Cross NC. Claims can be submitted via three methods: paper, electronic, and EDI batches.



Newborn Claims

Regarding Newborn claims submission and the creation of the newborn's temporary ID:

- Newborns whose mothers are covered by Blue Cross NC at the time of birth, will be assigned coverage with the plan.
- Newborn deliveries exceeding 48 hours after a vaginal delivery or 96 hours after a Cesarean section will require prior authorization.
- Newborns must have their permanent assigned Medicaid ID prior to the provider billing for services. ***The newborn's delivery is charged to the mother's subscriber ID, but all services rendered to the newborn are billed under the newborn's subscriber ID***
- Newborn claims should not and cannot be billed under the mother's Medicaid ID number.
- Hospitals are required to follow the reporting requirements for hospital acquired conditions.

- Blue Cross NC will report the deemed newborn's birth to North Carolina Department of Health and Human Services (NC DHHS) within five calendar days upon notification of birth.

Refer to the **Provider Playbook 2023 NC Medicaid Managed Care Eligibility for Newborns: What Providers Need to Know** for additional information on newborns.

Claims Submission Via Electronic Visit Verification (EVV) Platform

EVV is the electronic verification process for Medicaid Home and Community-Based Services (HCBS) performed in a member's home. An EVV platform captures six data points in real time: (1) date, (2) location, (3) start and end time, (4) service provided, (5) caregiver providing service, and (6) member receiving service.

CareBridge is the Healthy Blue EVV vendor. Providers may choose CareBridge or a different vendor for their EVV platform. Regardless of the selected vendor, all provider claims that are subject to EVV rules must be submitted via an EVV platform that is integrated with the CareBridge system. If EVV subjected claims are manually submitted via Availity, then the claim will be denied.

Providers should refer to the **CareBridge Billing Guide** for additional guidance on claims submission and resolution of prebilling rejections and denied claims.

For more information on EVV, EVV Next Steps, or CareBridge, contact the CareBridge Support Center at ncevv@carebridgehealth.com or call **855-782-5976**.

Other Health Insurance

Consistent with the Council on Affordable Quality Healthcare's (CAQH), Blue Cross NC uses standard Claim Adjustment Group Codes (CAGC), Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) to communicate claim adjudication.

Tribal Claims

Cherokee Indian Hospital Authority (CIHA) will bill for inpatient and outpatient services in accordance with current Medicaid requirements for North Carolina. Other eligible tribal providers will receive the All-Inclusive Rate (AIR), also referred to as the OMB rate, for services rendered at CIHA and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January.

Prior Authorization

Providers can visit the **Availity Essentials** website to request prior authorization. Through this secure provider website, you can access the Interactive Care Reviewer (ICR), which offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical and OHI behavioral health services for Healthy Blue members.

Interactive Care Reviewer (ICR)

Providers can use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, ICR or another online tool).

Providers can access ICR by selecting **Patient Registration** from Availity's homepage, then choose **Authorizations and Referrals**. ICR allows providers to do the following:

- Initiate preauthorization requests online, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Review requests previously submitted via phone, fax, ICR or another online tool.
- Gain instant accessibility from almost anywhere, including after business hours.
- Use the dashboard to provide a complete view of all utilization management requests with real-time status updates.
- Get real-time results for some common procedures.
- Access ICR by selecting **Patient Registration** from Availity's homepage, then choose **Authorizations and Referrals**. To access ICR, you will need to have your own Availity unique ID and password and have the appropriate Availity role assignment. Your Availity administrator should assign you the Authorization and Referral Request role or the Authorization and Referral Inquiry role.

For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Chrome, Firefox, or Safari.

Prior authorization requests for radiology & cardiology services rendered on or after November 1, 2022, are obtained through AIM Specialty Health®. Providers must register at the **AIM Specialty Health** website for access to the secure provider portal. Providers are strongly encouraged to obtain prior authorization before initiating, scheduling, and performing services.

Prior Authorization (PA) of All Inpatient Elective Admissions

Prior authorization, also known as precertification, is required for all inpatient elective admissions. The provider rendering the services is responsible for obtaining the PA. The requesting physician identifies the need to schedule a hospital admission.

Providers can submit their PA request via one of the following options:

- Submit the request online via the Interactive Care Reviewer (ICR) at **Availity Essentials**
- Fax the request to **855-817-5788**
  - For behavioral health inpatient, fax to **844-439-3574.**
  - For behavioral health outpatient, fax to **844-429-9636.**
- Contact Healthy Blue Provider Services at **844-594-5072.**

PA requests must include all supporting documentation upon identifying the inpatient need or at least 72 hours prior to the scheduled admission. This will allow us to verify benefits and process the precertification request. For services that require precertification, we make case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care.

Hospitals can confirm that a prior authorization is on file by:

- Visiting **Patient360** on the Availity Essentials website.
- Calling Healthy Blue Provider Services at **844-594-5072**.
    - If coverage of an admission has not been approved, the facility should call Healthy Blue Provider Services. We will contact the referring physician directly to resolve the issue. We are available 24/7 to accept precertification requests.
    - When a request is received from the physician online, via phone or by fax for medical services, a care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse. Our precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of all procedures.
    - When appropriate, our precertification nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.
    - To learn more about ICR navigation and features, register for one of our ICR provider webinars.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, we will issue a Healthy Blue reference number to the requesting physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

- If medical necessity criteria for the admission are not met on the initial review, the requesting provider will be able to discuss the case with the Healthy Blue medical director prior to the determination.
- If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the requesting provider to submit the additional necessary documentation.
- If the medical director denies coverage of the request, the appropriate denial letter (including the member's appeal and fair hearing appeal rights) will be mailed to the requesting provider, member's Primary Care Physician (PCP) and member.

Emergent Admission Requirements

Network hospitals must notify us within 24 hours or the next business day of an emergent admission.

Network hospitals can notify us by calling Healthy Blue Provider Services 24/7 at **844-594-5072**, by fax at **844-451-2694** or online at the **Healthy Blue provider** website.

Our Medical Management staff will verify eligibility and determine coverage. A concurrent review nurse will review and authorize the coverage of emergent admissions based on medical necessity. All clinical documentation must be complete. We will notify the hospital to submit whatever additional documentation is necessary. If our medical director denies coverage, the attending provider will have an opportunity to discuss the case with him or her. The attending emergency room physician or provider treating the member is responsible until, and will determine when, the member is stabilized. We will mail a denial letter to the provider and the member and include the member's appeal and fair hearing rights and process.

Nonemergent Outpatient and Ancillary Services — Precertification and Notification Requirements

We require precertification for coverage of certain nonemergent outpatient and ancillary services. To ensure timeliness, you must include the following:

- Member name and ID
- Name, phone number and fax number of the physician providing the service
- Name of the facility and phone number where the service will be performed
- Name of servicing provider and phone number
- Date of service
- Diagnosis using ICD-10-CM
- Name of elective procedure with HCPCS or CPT-4 code
- Medical information to support the request: signs and symptoms
- Past and current treatment plans, along with the provider who provided the surgery
- Response to treatment plans
- Medications, along with frequency and dosage

Specialized Therapy Prior Authorizations

- All therapies are done by visits (not units)
- Utilization Management (UM) reviews and processes in ***visits*** not ***units***
    - Example: If a provider sends over a PA request for 160 units, UM will divide and approve 40 visits
- Visits drive the therapy
- Units drive claim adjudication
- For speech therapy, the determination is based on severity, such as:
    - Mild impairment range of visits: 6 to 26
    - Moderate impairment range of visits: up to 46
    - Severe impairment range of visits: up to 52
        - Example: A peds patient may have as many as 52 visits; however, even though an adult patient is reviewed on severity they cap out at 27 visits

Frequently Asked Questions about Therapy Authorizations

What are the coverage limitations for therapy services? Does it vary by patient age?

- Therapy requests for individuals ***under 21*** are based on medical necessity.
- Therapy requests for individuals ***21 and over*** has a **coverage limitation** of 27 visits.
- Therapy groups have full control of how they choose to combine the 27 visits.
- Therapy requests for over 27 visits are sent to the Medical Director (MD) for review.

Is the prior authorization issued under the group name or the rendering therapist?
The authorization is issued under the provider who has been designated as the rendering provider when the PA request is submitted.

How are the prior authorizations sent to the providers?

- Approvals are auto generated and mailed out.
- Our UM manual letter team sends out denial notifications via fax, which is followed up by a denial letter in the mail.
- If the PA request is reduced, UM auto generates an approval letter for the approved portion and follow the manual letter process for reduced portion.

What information is displayed on the authorization? Does it specify the CPT codes the provider requested?
If the CPT code is submitted correctly, the Healthy Blue Utilization Management (UM) team can see the code on the request. The UM team utilizes the service group for the CPT code and list it on the approval.

Vendors

Vendors are any providers, suppliers, manufacturers, and any other individual or entity regardless of the service the vendor provides. We work with several organizations to provide our members with quality services. For more information about these organizations and the services they provide, please see below:

EyeMed

EyeMed is an independent company providing vision services for Healthy Blue members on behalf of Blue Cross NC, including routine, dispensing, medical and surgical services.

EyeMed will not be administering routine eyeglasses. Eyewear policies will follow those outlined by North Carolina Division of Health Benefits and providers will continue to order all covered eyewear directly from Correction Enterprises fabricated at Nash Optical Plant.

Vision services must be submitted to EyeMed. If you are a vision provider, please set up your online claims system account by visiting **www.eyemed.com**.

EyeMed is directly connected with clearinghouses such as Trizetto, nThrive, Change Healthcare, and TKSoftware.

For training and clinical guidelines, please visit **eyemedinfocus.com**.

Modivcare

Modivcare Solutions is an independent company providing non-emergency medical transportation (NEMT) services for Healthy Blue members on behalf of Blue Cross NC.

All NEMT requests do not require a prior authorization and should be submitted to Modivcare. A minimum of a two-day notice is required, except in the case of life-sustaining treatments, such as dialysis, chemotherapy, or discharge from the hospital.

All questions regarding reservations and ride assistance should be directed to Modivcare by contacting them at **855-397-3602.**

Note: Telecommunication services are available at **866-288-3133**.

Refer to **https://modivcare.com** for further information on NEMT.

Tobacco Cessation

The Healthy Blue Tobacco Cessation Plan focuses on the following:

- Collaborate and align Blue Cross NC's approach with NC DHHS guidance to include design of benefit coverage and educational campaigns for providers and members
- Maintain open access to member benefits with ability to self-refer to the Optum Quit for Life® program and removal of barriers related to prior authorizations, co-pays, maximum benefit limits, or cost limits.
- Increase member awareness of benefits through multiple avenues of communication (in other words, live, focused telephonic member outreach campaigns, text/IVR messaging, referrals from medical management staff, and various routes of written communication).
- Advance current tobacco cessation clinical guidelines through network provider training and provider forums, including emphasis on development of tobacco-free policies for medical and behavioral campuses.
- Measure strategy impact through tracking of program metrics.

Member benefits are designed to meet current standards of care for treatment of tobacco use. The Healthy Blue tobacco cessation program adheres to the current standard of four sessions covering at least 90 minutes of individual, group, or telephone counseling, two or more times per year. There is no prior authorization required for tobacco cessation counseling. In addition, there are no co-pays, maximum benefit limits, cost limits or annual limit on quit attempts.

Medication Therapy

The Healthy Blue formulary includes the current standard of care for treatment with 12 weeks of Varenicline or combination nicotine therapy (patches plus gun/lozenges), two or more times per year. Multiple prescription and over-the-counter options are available. The cost of medication therapy is covered by Blue Cross NC when a prescription is presented to any in-network retail pharmacy or through pharmacy mail order. Over the counter, FDA-approved

tobacco cessation medications require no prior authorization or co-pays, and there are no quantity limits.

Quitline Vendor Resources

Blue Cross NC partners with Optum Quit For Life®, a Quitline vendor, to provide telephonic tobacco cessation counseling and coordinated medication therapy. The program is based upon evidence-based standards of care and focused on life-long behavior change. Services are delivered through an integrated telephonic and web-based approach.

The Optum Quit For Life® Program scope includes the following:

- Four call sessions with the general member population.
- 10 call sessions with women who plan to become pregnant within three months, pregnant women and women who gave birth within the year prior to Quitline contact.
- 12 weeks of nicotine patch plus gum or lozenge therapy for members that are not pregnant of breastfeeding.
- 12 weeks of nicotine gum or lozenge therapy for pregnant or breastfeeding women with a medical override.
- Specialized behavioral health protocols with 12 weeks combo nicotine replacement therapy and seven calls from dedicated mental health trained Quitline coaches.
- Promotion of Quitline services to members and provider with partnership in development, review, and approval from Quitline vendor and the North Carolina Department of Health Tobacco Prevention and Control Branch (TPCB).
- Data use agreement to allow sharing of program de-identified member data extracts with the TPCB.

Additional program offerings include:

- Coordination of pharmacy benefits for Healthy Blue members to support the standard of care to include a 12 week regimen of Varenicline or combination nicotine therapy (patches plus gum/lozenge) two or more times per year.
- Unlimited toll-free telephone access 24 hours a day, seven days a week for 12 months following participants' enrollment date, excluding holidays.
- Offer of program re-enrollment to participants who do not self-report as having quit at the last phone call or at the six-month follow-up survey (Continuum of Care).
- Access to web-based portal support for participants with email addresses.
- Text messages integrated with the program for up to 12 months following participants' enrollment date.
- A Quit Guide containing educational content, tips and tools pertinent to tobacco cessation.
- A Media Resource Center with materials to leverage promotion of the Quit for Life® program

National DME Miscellaneous and Corresponding Local W Codes

Providers must submit both the national DME miscellaneous and corresponding local W codes on claims based on the chart below. Local codes should be noted in the service description as

they will fail National Uniform Billing Committee service validations if used as the principal service. If the specified local W codes are not on the claim, your claim(s) may be denied.

National	Description	Local	Local description
E1399	DME, miscellaneous	W4001	CO2 saturation monitor with accessories, probes
E1399	DME, miscellaneous	W4002	Manual ventilation bag (for example, Ambu bag)
K0108	Wheelchair component or accessory, not otherwise specified	W4005	Unlisted replacement or repair parts
E1399	DME, miscellaneous	W4016	Bath seat, pediatric (for example, TLC)
E1399	DME, miscellaneous	W4047	Miscellaneous for DME
K0108	Wheelchair component or accessory, not otherwise specified	W4117	Wheelchair seat width, greater than 27"
K0108	Wheelchair component or accessory, not otherwise specified	W4118	Wheelchair seat depth, greater than 25"
K0108	Wheelchair component or accessory, not otherwise specified	W4119	Wheelchair seat height, cost-added option from manufacturer
E1399	DME, miscellaneous	W4120	Disposable bags for InspirEase inhaler system, set of 3
K0108	Wheelchair component or accessory, not otherwise specified	W4130	Contoured or 3-piece head/neck supports with hardware, each
K0108	Wheelchair component or accessory, not otherwise specified	W4131	Basic head/neck support with hardware, each
K0108	Wheelchair component or accessory, not otherwise specified	W4132	Contoured or 3-piece head/neck support with multi-adjustable hardware, each
K0108	Wheelchair component or accessory, not otherwise specified	W4133	Basic head/neck support with multi-adjustable hardware, each
K0108	Wheelchair component or accessory, not otherwise specified	W4139	Subasis bars with hardware, each
K0108	Wheelchair component or accessory, not otherwise specified	W4140	Abductor pads with hardware, pair

National	Description	Local	Local description
K0108	Wheelchair component or accessory, not otherwise specified	W4141	Knee blocks with hardware, pair
K0108	Wheelchair component or accessory, not otherwise specified	W4143	Shoe holders with hardware, pair
K0108	Wheelchair component or accessory, not otherwise specified	W4144	Foot/leg rest cradle, each
K0108	Wheelchair component or accessory, not otherwise specified	W4145	Manual tilt-in-space option, each
K0108	Wheelchair component or accessory, not otherwise specified	W4150	Multi-adjustable tray, each
K0108	Wheelchair component or accessory, not otherwise specified	W4152	Growth kit, each
E1399	DME, miscellaneous	W4153	Tracheostomy ties, twill, each
K0108	Wheelchair component or accessory, not otherwise specified	W4155	Adductor pads with hardware, pair
B9998	NOC for enteral supplies	W4211	Low profile gastrostomy extension/replacement kit for continuous feeding, each
B9998	NOC for enteral supplies	W4212	Low profile gastrostomy extension/replacement kit for bolus feeding, each
E1399	DME, miscellaneous	W4670	Sterile saline, 3 cc vial, each
E1399	DME, miscellaneous	W4678	Replacement battery for portable suction pump adaptic and transparent type such as Tegaderm or Opsite for use with external insulin pump, each
E1399	DME, miscellaneous	W4688	Single-point cane for weights 251# to 500#
E1399	DME, miscellaneous	W4689	Quad cane for weights 251# to 500#
E1399	DME, miscellaneous	W4690	Underarm crutches for weights 251# to 500#

National	Description	Local	Local description
E1399	DME, miscellaneous	W4691	Fixed-height forearm crutches for weights to 600#
E1399	DME, miscellaneous	W4695	Glides/skis for use with walker
K0108	Wheelchair component or accessory, not otherwise specified	W4713	Oversized footplates for weights 301# and greater, pair
K0108	Wheelchair component or accessory, not otherwise specified	W4714	Swing away special construction footrests for weights 401# and greater, pair
K0108	Wheelchair component or accessory, not otherwise specified	W4715	Swing away reinforced leg rest, elevating, for weights 301# to 400#, pair
K0108	Wheelchair component or accessory, not otherwise specified	W4716	Swing away special construction leg rests, elevating, for weights 401# and greater, pair
K0108	Wheelchair component or accessory, not otherwise specified	W4717	Oversized calf pads, pair
K0108	Wheelchair component or accessory, not otherwise specified	W4718	Oversized solid seat
K0108	Wheelchair component or accessory, not otherwise specified	W4719	Oversized solid back
K0108	Wheelchair component or accessory, not otherwise specified	W4722	Oversized full support footboard
K0108	Wheelchair component or accessory, not otherwise specified	W4723	Oversized full support calf board
E1399	DME, miscellaneous	W4733	Replacement oversized innerspring mattress for hospital bed with width to 39"

Physician Administered Drug Program

The below guidance is to support usage of the HCPCS/NDC Crosswalk regarding drugs and products covered under the medical pharmacy benefit.

Note: Reference the **PDP Frequently Asked Questions** for more information.

Professional Claim Submission Guidance

- Billed on the *CMS-1500* or 837P.
- Drugs are rebate eligible.

- The PADP program applies to professional claims. *(Per the PADP NC Medicaid Policy 1B, some drugs and products are excluded from rebate eligibility.)*
- Drugs pay per the PADP fee schedule.
- All HCPCS/NDC combinations for acceptable drugs are on the crosswalk table.

Outpatient Dialysis Centers Submission Guidance

- Billed on a *UB-04* or 837I with a dialysis taxonomy (261QE0700X).
- Dialysis center claims pay based on the composite rates per the dialysis policy, 1A-34.
- Drugs not included in the composite rate(s) and billed separately **must be rebate eligible.**
- A valid HCPCS code and a valid/active NDC must be present on the claim.

Outpatient Hospital (Excluding Dialysis)

- Billed on a *UB-04* or 837I.
- Drugs must be rebate eligible.
- Drugs not included in the composite rate(s) and billed separately must be rebate eligible and paid based on the PADP fee schedule.
- Outpatient hospitals can bill for covered outpatient drugs, and they are not restricted to the drugs listed on the PADP.
    - Outpatient hospital payment is based on the Ratio of Cost to Charge (RCC) methodology.

Inpatient Hospital Claims

- Billed on a *UB-04* or 837I.
- Rebates are not collected for inpatient drugs.
- The PADP program is not applicable to inpatient claims.
- DRG pricing is applied.
- Inpatient hospital claims for rehab and psych are reimbursed under the per diem methodology.
- The HCPCS/NDC crosswalk does not apply to inpatient claims.

Abortions

Providers must properly execute and submit the state approved Abortion Statement along with the provider's claim. Please refer to Attachment B of **Clinical Coverage Policy 1E-2** and the **Reproductive Health Forms** section of the Healthy Blue provider website for additional guidance regarding completing the Abortion Statement. Failure to submit the required Abortion Statement will result in a claim denial.

Sterilizations

Providers must properly execute and submit state approved *Sterilization Consent Form* along with the provider's claim. Please refer to Attachment B of **Clinical Coverage Policy 1E-3** and the **Reproductive Health Forms** section of the Healthy Blue provider website for additional guidance regarding completing the *Sterilization Form*. Failure to submit the required *Sterilization Consent Form* will result in a claim denial.

Hysterectomy

Providers must properly execute and submit state approved Hysterectomy statement along with the provider's claim. Please refer to Attachment B of **Clinical Coverage Policy 1E-1** and the **Reproductive Health Forms** section of the Healthy Blue provider website for additional guidance regarding completing the Hysterectomy Statement. Failure to submit the required Hysterectomy Statement will result in a claim denial.

Present on Admission (POA) Indicators

Acceptable Present on Admission Indicators and Description

Indicator	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation is insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	This code is the equivalent of a blank on the *UB-04*; however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1. Note: The number **1** is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for codes exempt from POA reporting.

Early Elective Deliveries (EED)

Blue Cross NC reimburses for EED (labor without medical necessity followed by vaginal or caesarean section delivery or a delivery by caesarean section before 39 weeks' gestation without medical necessity). Vaginal or caesarean delivery following non-induced labor is not considered an EED, regardless of gestational weeks.

Note: EED is strongly discouraged before 39 weeks unless medically necessary.

Providers are required to use a Z3A code indicating gestational age, the appropriate code to indicate the outcome of delivery, and supporting medical necessity diagnosis codes on all professional delivery claims for all EEDs. Blue Cross NC applies MCG Care Guidelines, which define medically necessary criteria for EEDs. All professional delivery claims (59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, and 59622) require a Z3A code indicating the gestational age at the time of delivery. If the code is not on the claim, the claim will deny with the explanation code e02 – Delivery diagnoses incomplete without report of pregnancy weeks of gestation. Professional delivery claims with gestational ages of 37 and 38 weeks require a supporting medically necessary diagnosis code for an early delivery. If a professional delivery claim is submitted without evidence of medical necessity, the claim will deny with the explanation code k34 – Delivery is not medically indicated.

Skilled Nursing Facilities

For individuals enrolled in a Medicaid managed care plan through Blue Cross NC, the following is the process:

- The SNF needs to request an authorization for services.
- Once Blue Cross NC reviews and approves, the authorization approval letter is sent to the provider.
- The provider then sends the authorization approval letter to the local DSS for the Patient Monthly Liability (PML) to be reviewed.

Once the local DSS reviews PML and approves, Blue Cross NC is notified via the enrollment file. Blue Cross NC can then process claims.

Note: If claims are submitted and the PML ***has not*** been received from the local DSS, claims will deny with a disallowed code of ***R18- Initial Evaluation*** needed. Once the PML is received Blue Cross NC can reprocess impacted claims.

Unlisted CPT Codes

Blue Cross NC allows for reimbursement of unlisted, unspecified, or miscellaneous codes in accordance with state guidelines, and/or requirements. Unlisted, unspecified, or miscellaneous codes should only be used when an established code does not exist to describe the diagnosis, service, procedure, or item rendered. Reimbursement is based on review of the unlisted, unspecified, or miscellaneous code(s) on an individual claim basis. Claims submitted with unlisted, unspecified, or miscellaneous codes must contain the following information and/or documentation for consideration during review:

- A written description, office notes or operative report describing the procedure or service performed
- An invoice and written description of items and supplies
- The corresponding National Drug Code number for an unlisted drug code

Vaccines For Children

Blue Cross NC allows for reimbursement of the administration fee for vaccines provided by the Vaccines for Children (VFC) Program for eligible Medicaid members under the age of 19 unless provider, state, Federal or CMS contracts and/or requirements indicate otherwise.

Medicaid providers who participate in the VFC Program and immunize children shall comply with all the reporting requirements and procedures. Although providers are only reimbursed for the administration of the vaccine, serum code(s) must be included on the claim to meet regulatory and HEDIS reporting requirements. Claims submitted without applicable serum, administration and modifier codes may be rejected and/or denied.

Refer to the **Centers for Disease Control and Prevention Vaccine Price List** for a complete list of vaccines and NDCs that qualify for VFC program.

Telehealth/Telemedicine

Blue Cross NC allows for reimbursement of live video medical services and tele-psychiatry services. All the following conditions must be met:

- The beneficiary must be present at the time of consultation.
- The medical examination must be under the control of the consulting provider.
- The distant site of the service must be of a sufficient distance from the originating site to provide services to a beneficiary who does not have readily available access to such specialty services; and
- The consultation must take place by two-way real-time interactive audio and video telecommunications system.

Services provided via telehealth must be provided in an amount, duration, and scope no less than the amount, duration and scope for the same services furnished to beneficiaries under the Medicaid fee-for-service program.

You can also review the telehealth **Clinical coverage policy 1H** for additional information regarding claims related information.

Appeals and Grievances

Blue Cross NC has a specific provider claim payment dispute process. A provider claim dispute is considered a grievance. If a provider disagrees with the outcome of a finalized claim, they may file a claims payment dispute. The claims dispute process consists of two steps. Claims payment reconsideration is the first step in the claim payment dispute process. The reconsideration represents the initial request for an investigation into the outcome of the claim and must be submitted within 90 calendar days of the date on the explanation of payment. A claim payment appeal is the second step in the claim payment dispute process.

If a provider disagrees with the outcome of the reconsideration, the provider may request an additional review within 30 calendar days of the reconsideration determination.

A claim payment dispute may be submitted for one or multiple reason(s), including:

- Contractual payment issues
- Disagreements over reduced or zero-paid claims
- Claim code editing issues
- Post-service authorization issues
- Claim coding edit issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues
- Timely filing issues
- We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if the provider can do one of the following:

- Provide documentation the claim was submitted within the timely filing requirements
- Demonstrate that good cause exists

How to submit a provider claim(s) payment dispute

There are several options for filing a provider dispute:

- **Online**: Use the Availity secure provider payment appeal feature located on claims status at **https://www.availity.com.** Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission.
  - Locate your claim to be disputed in claim status
  - Select the dispute button and follow wizard
  - Navigate to the Availity Appeal tool to upload your document
- **Written:** Mail all required documentation including the *Claim Payment Appeal Form* or the *Reconsideration Form* to:

  Blue Cross NC | Healthy Blue
  Provider Grievance and Appeals
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

- **Verbally**: Providers can contact Healthy Blue Provider Services at **844-594-5072** and select the claims prompt within our voice portal. Providers will be connected with a dedicated resource team to:
  - Increase first-contact issue resolution rates.
  - Improve turnaround time of inquiry resolution.
  - Increase outreach communication to keep you informed of your inquiry status.

Rural Health Clinics and Federally Qualified Health Centers

Rural Health Clinic (RHC) Services

Congress passed *Public Law 95-210, the Rural Health Clinic (RHC) Services Act*, in December 1977. The *Act* authorized Medicare and Medicaid payments to certified rural health clinics for *physician services* and *physician-directed services* whether provided by a physician, physician assistant, nurse practitioner, or certified nurse midwife. The *RHC Act* established a core set of healthcare services. Child health assistance in RHCs is authorized for NC Health Choice beneficiaries in *42 USC 1397jj(a)(5)*.

The specific healthcare encounters that constitute a core service include the following face-to-face encounters:

- Physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered
- Services provided by physician assistants and incident services supplied

- Nurse practitioners and incident services supplied
- Nurse midwives and incident services supplied
- Clinical psychologists and incident services supplied
- Clinical social workers and incident services supplied

Federally Qualified Health Center (FQHC) Services:

Section 6404 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the *Social Security Act* effective April 1, 1990, to add FQHC services to the Medicaid program.

Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of healthcare services. Child health assistance in FQHCs is authorized for NC Health Choice beneficiaries in *U.S.C. 1397jj(a)(5)*.

The specific healthcare encounters that constitute a core service include the following face-to-face encounters:

- Physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered.

In addition, per **Clinical Coverage Policy No: 1D-4** Attachment A:
FQHC and RHC core service providers may conduct telehealth visits with a supporting home visit by a delegated staff member (hybrid model) with new or established patients and bill using HCPCS code T1015 (or T1015-HI, T1015-SC), for a range of scenarios including (but not limited to) chronic disease management and perinatal visits.

Additional Guidance

- Well-child services are not eligible to be delivered via the hybrid model.
- The delegated staff person may perform vaccinations in the home as long as they comply with applicable vaccination requirements (for example, staff person's scope of practice), and may conduct other tests or screenings, as appropriate.
    - Any vaccinations, tests or screenings conducted in the home should be billed as if they were delivered within the office.
- FQHCs and RHCs may bill their core service code (T1015, T1015-HI, or T1015- SC) and an originating site facility fee (Q3014) for hybrid model visits to reflect the additional cost of the delegated staff person attending the patient's home. To be reimbursed for the originating site facility fee, all the following requirements must be met for each home visit:
    - The assistance delivered in the home must be given by an appropriately trained delegated staff person.
    - The fee must be billed for the same day that the home visit is conducted.
    - HCPCS code Q3014 must be appended with the GT modifier and billed with a place of service *12* to designate that the originating site was the home.

- The core service code (T1015, T1015-HI or T1015-SC) must be billed as a separate claim from the originating site facility fee code (Q3014).

If services are provided on the same day, please review the **Clinical Coverage Policy No:1D-4** Attachment B:

- Claims for core services are billed with the FQHC's or the RHC's NPI number.
- The NPI number of the medical provider is not entered in block 33 of the *CMS-1500* claim form, when billing a core visit or other health service core visit.
- If another *health* visit, such as a behavioral health visit, and a medical visit occur on the same day as a core visit, clinic bills T1015 (HI) for the behavioral health visit and T1015 for the medical visit.
- When an on-site radiology service and a core service are performed on the same date of service, the FQHC or RHC bills on two separate claims: the professional encounter is included under the T1015, and the technical component of the radiology service is billed using the FQHC or RHC rendering provider number.
- Laboratory services furnished by the FQHC or RHC are not core services and are reimbursed based on the fee schedule allowable for the FQHC or RHC.
- The insertion, removal, or removal with re-insertion of implantable contraceptive devices that are Medicaid approved is included in the core service and is not separately reimbursed to the FQHC or RHC. The drug itself is separately reimbursable.
- An FQHC or RHC that is not enrolled in the pharmacy program bills Depo-Provera injections for family planning on the *CMS-1500* claim form using the FQHC or RHC rendering provider's NPI number.
- Antepartum care and postpartum care are core services. They are not reported using the all-inclusive CPT obstetrics procedure codes that include antepartum and/or postpartum care. The number of antepartum (core service) visits is unlimited and is determined by the physician's assessment and documentation for medical necessity. When the FQHC or RHC provider performs the delivery, the FQHC or RHC bills the delivery only or C-section only codes.
- The services described by procedure code 99408 (alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST) and brief intervention (SBI) services; 15-30 minutes and procedure code 99409 (alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST) and brief intervention (SBI) services (greater than 30 minutes) should be billed using T1015 with the HI modifier.
- Family planning services for *Be Smart* Family Planning Medicaid beneficiaries are not core services and should be billed as physician services. Refer to **1E-7 Family Planning Services Policy** for specific billing information.

Note: FQHC/RHC core services are clinical services. Clinical services are not listed as services that require copayments. FQHC/RHC core services are exempt from copayments.

Appendix A

Definition of terms

Term	Definition
Claim	A formal request to receive payment from a payer for healthcare services rendered by a healthcare provider. The request includes information about the services provided, diagnosis, and other relevant information.
Clean claim	A request for payment for a service rendered by a provider that is accurate, submitted timely on a standard claim form (*CMS-1500* or *UB-04*) and requires no further information, adjustment, or alteration to be processed and paid. A clean claim is not a claim under review for medical necessity or from a provider who is under investigation for fraud or abuse.
Corrected claim	A replacement of a previously submitted claim (for example, changes or corrections to charges, clinical or procedure codes, dates of service, member information, etc.). A corrected claim is not an inquiry or appeal.
Denial	A claim that has been received and processed by the payer but have been marked as unpayable.
Division of Health Benefits (DHB)	The Division of Health Benefits (DHB) is a division within the North Carolina Department of Health and Human Services (NC DHHS); which governs the North Carolina Medicaid and NC Health Choice programs .
Division of Social Services	The Division of Social Services (DSS) provides guidance and technical assistance to agencies that provide direct services that address issues of poverty, family violence and exploitation. DSS promotes self-reliance and self-sufficiency and works to prevent abuse, neglect, dependency and exploitation of vulnerable individuals, children, and their families.
Encounter	Record of a medically related service (or visit) rendered by a provider to a beneficiary who is enrolled in a participating health plan during the date of service; it includes but is not limited to all services for which the health plan incurred any financial responsibility.
Healthy Blue	Healthy Blue is the Medicaid plan offered by Blue Cross NC to serve North Carolinians who participate in the state Medicaid managed care program.
Interim claim	A series of claims for a course of treatment when a patient is expected to remain in the facility for an extended period or when a member's benefit crosses calendar or benefit years.
NCTracks	NCTracks is a multi-payer Medicaid Management Information System for the North Carolina Department of Health and Human Services (NC DHHS). NCTracks is provided as a service for North Carolina's healthcare providers and consumers as part of the multi-program Medicaid Management Information System.

Term	Definition
Rejected claim	A claim that may contain one or more errors that were found before the claim was ever processed or accepted by the payer. A rejected claim is typically the result of a coding error, a mismatched procedure and ICD code(s), or a termed patient policy.
Standard plan	The North Carolina Department of Health and Human Services (NC DHHS) transitioned most Medicaid beneficiaries to standard plans on July 1, 2021. Standard plans are integrated health plans that provide: • Physical health, pharmacy, care coordination and basic behavioral health services. • Added services, such as wellness programs. • Standard plans have a provider network that includes doctors, therapists, specialists, hospitals, and other healthcare facilities to provide healthcare services to their members.
Tailored plan	A tailored plan is a Medicaid health plan. It offers physical health, pharmacy, care management and behavioral health services. It is for members who may have significant mental health needs, severe substance use disorders, intellectual/developmental disabilities (I/DDs) or traumatic brain injuries (TBIs). Tailored plans offer added services for members who qualify. Tailored plan auto-enrollment began August 15, 2022. If you are auto enrolled in a tailored plan or have the option to choose a tailored plan, you will receive a notice in the mail. Tailored plans are scheduled to go live April 1, 2023. **Note**: Blue Cross NC is ***not*** a tailored plan.
Voided claim	A claim that was originally paid, and then later was canceled and the payment taken back. Void (cancel) the original claim to stop the processing of the claim, or to allow you to submit a corrected version.

Appendix B

Professional Claims Submission Requirements

Field #	Field name	Required Y = Yes N = No S = Situational	Description format	Example
1	Type	N	Check appropriate box	X
1 a	Insured ID	Y	Healthy Blue member ID including alpha prefix	GJN123456789
2	Patient Name	Y	Last name, first name, middle initial	Doe, John, E
3	Patient Date of Birth	Y	MM/DD/YY	07 04 99
3	Patient Sex	Y	Check M box for male,F box for female	X
4	Insured's Name	S	Last name, First name, Middle initial	Doe, John, E
5	Patient's Address	Y	Number and street	123 Somewhere St
5	Patient's City	Y	City	Anytown
5	Patient's State	Y	State abbreviation	VA
5	Patient's ZIP Code	Y	U.S. Postal ZIP code	12345-0001
5	Patient Phone	N	Area code plus phone number (10digits)	757-123-4567
6	Patient Relationship to Insured	N	Check appropriate box	X
7	Insured Street	S	Number and street	123 Somewhere St
7	Insured City	S	City	Anytown
7	Insured State	S	State abbreviation	VA
7	Insured ZIP Code	S	U.S. Postal ZIP code	12345-0001
7	Insured Phone	N	Area code plus phone number (10digits)	757-123-4567
8	Patient Status	S	Check appropriate box	X
9	Other Insured Name	S	Last name, first name, middle initial	Doe, Mary, D
9 a	Other Insured Policy or Group Number	S	Other insured member ID	555666777888
9 b	Other Insured Date of Birth	S	MM/DD/YY	03 15 87
9 b	Other Insured Sex	S	Check M box for male, F box for female	X
9 c	Other Employer/School	S	Name of employer or school	Some Bank Name Inc.
9 d	Other Insurance Name	S	Name of other insurance	For All Commercial Insurance
10 a	Work Related Condition	S	Check appropriate box	X
10 b	Auto Related Condition	S	Check appropriate box	X
10 b	Accident Place State	S	State abbreviation	VA
10 c	Other	S	Check appropriate box	X
10 d	Local Use	N		
11	Insured Policy Group or FECA Number	S	Insured group number	FAC111222B
11 a	Insured Date of Birth	S	MM/DD/YY	07 04 99

Field #	Field name	Required Y = Yes N = No S = Situational	Description format	Example
11 a	Insured Sex	S	Check M box for male, F box forfemale	X
11 b	Insured Employer/School	S	Enter employer or school name	NONE
11 c	Insured Plan Name	S	Insurance plan name	Medicaid
11 d	Other Benefit Indicator	S	Check appropriate box	X
12	Patient/Authorized Signature	N		
12	Patient/Authorized Date	N		
13	Insured/Authorized Signature	N		
14	Illness/Injury Date	S	MM/DD/YY	02 09 08
15	Similar Illness Date	S	MM/DD/YY	12 16 07
16	Disability Date — From	S	MM/DD/YY	02 05 08
16	Disability Date — To	S	MM/DD/YY	02 11 08
17	Referring Physician Name	S	Name of physician who referredpatient for services	Jane A Smith
17 a	Referring Physician ID Qualifier	S	Use corresponding qualifier for ID number submitted in 17a — shaded: G2 = Healthy Blue number, 1D = Medicaid, ZZ = Taxonomy	ZZ
17 a	Referring Physician ID	S	Appropriate and valid provider ID: Medicaid, Blue Cross NC or Taxonomy	207QA0000X
17 b	NPI	S	Valid 10-digit NPI number	9876543210
18	Hospitalization Date — From	S	MM/DD/YY	02 08 08
18	Hospitalization Date — To	S	MM/DD/YY	02 09 08
19	Local Use	N		
20	Outside Lab	S	Check appropriate box	X
20	Lab Charges	S	Dollar amount from outside lab	60 00
21 1.	Diagnosis Code	Y	Valid primary diagnosis code	821.3
21 2.	Diagnosis Code	S	Valid secondary diagnosis code	
21 3.	Diagnosis Code	S	Valid tertiary diagnosis code	
21 4.	Diagnosis Code	S	Valid fourth diagnosis code	
22	Medicaid Resubmission Code	N		123
22	Medicaid Original Reference	N	Original claim number	ABC123456789
23	Prior Authorization Number	S	If authorization for services was obtained, enter the Healthy Blue authorization number. If the servicesreported on the claim require a *CLIA*certificate number, the *CLIA* numbershould be reported in place of the authorization number.	1234AUTH5678 or 12D4567890
24	Shaded Area Data	S	Free-form text and/or NDC information	N400186115102 ML 1
24 a	From Date	Y	MM/DD/YY	02 10 08
24 a	To Date	Y	MM/DD/YY	02 10 08
24 b	Place of Service	Y	2-digit place of service code	11

Field #	Field name	Required Y = Yes N = No S = Situational	Description format	Example
24 c	EMG	N	Emergency Indicator "Y" or blank = assumed "N"	Y
24 d	Procedure Code	Y	Valid CPT/HCPCS code	99212
24 d	Procedure Modifier 1	S	Valid 2-digit modifier	TN
24 d	Procedure Modifier 2	S	Valid 2-digit modifier	TC
24 d	Procedure Modifier 3	S	Valid 2-digit modifier	50
24 d	Procedure Modifier 4	S	Valid 2-digit modifier	51
24 e	Diagnosis Code Pointer	Y	Indicate which diagnosis code correlates to the line	1
24 f	Charges	Y	Charges for line	$150.00
24 g	Days or Units	Y	Appropriate number for days or units	1
2 h	EPSDT	Y	Y = if EPSDT service or N = if not an EPSDT service	N
24 i — shaded	ID Qualifier	S	Use corresponding qualifier for ID number submitted in 24j — shaded:G2 = Healthy Blue number, 1D = Medicaid, ZZ = Taxonomy	ZZ
24 j — shaded	Rendering Provider ID #	S	Appropriate and valid provider ID: Medicaid, Blue Cross NC or Taxonomy. Taxonomy required if Rendering NPI submitted.	207XP3100X
24j — not shaded	Rendering Provider NPI	S	Valid 10-digit NPI number Rendering required if Billing provideris a group.	1234567890
25	Federal Tax ID	Y	Valid 9-digit Tax ID or SSN	111223333
25	Federal Tax ID (SSN/EIN)	Y	Check SSN if social was used; checkEIN if Tax ID was used	X
26	Patient Account Number	S	Patient account number with provider	123ACCT456
27	Accept Assignment	S	Check appropriate box	X
28	Submitted Total Charge	Y	Total charges on claim	$250.00
29	Patient Amount Paid	S	Amount patient paid	$0.00
30	Balance Due	S	Amount still due on claim	$250.00
31	Signature of Physician/ Physician Name	Y	Rendering provider's name	Jack T Specialist
31	Performing Provider Date	N	MMDDYY	2/10/2008
32	Service Facility Location Name	S	Name of facility w here services w ere rendered	ABC Memorial Hospital
32	Service Facility Location Street	S	Number and street	987 Somewhere St.
32	Service Facility Location City	S	City	Anytown
32	Service Facility Location State	S	State abbreviation	VA
32	Service Facility Location ZIP Code	S	U.S. Postal ZIP code (9 digit)	12345-0001
32 a	NPI	S	Valid 10-digit NPI number	9871234567

Field #	Field name	Required Y = Yes N = No S = Situational	Description format	Example
32 b	Other ID	S	Appropriate and valid qualifier followed by provider ID: Medicaid, Blue Cross NC or Taxonomy	ZZ282NC2000X
33	Billing Provider Group Name	Y	Name of billing group or provider	JTS Orthopedic Specialists
33	Billing Provider Street	Y	Number and street. Do not submit P.O. Box.	222 Somewhere St
33	Billing Provider City	Y	City	Anytown
33	Billing Provider State	Y	State abbreviation	VA
33	Billing Provider ZIP Code	Y	U.S. Postal ZIP code (9 digit)	12345-0001
33	Phone Number	N	Billing provider phone number	757-555-4444
33 a	NPI	Y	Valid 10-digit NPI number	9874561230
33 b	Other ID	Y	Appropriate and valid qualifier followed by provider ID: Medicaid, Blue Cross NC or Taxonomy. Billing Taxonomy is required.	ZZ207X00000X

Appendix C

Facility Claims Submission Requirements

Field #	Field name	Required Y = Yes N = No S = Situational	Description format	Example
1	Billing Provider Name	Y	Facility name (ensure the name submitted matches the name used in the Healthy Blue processing system)	ABC Memorial Hospital
1	Billing Provider Street Address	Y	Number and street. Do not submit P.O.box.	987 Somewhere St.
1	Billing Provider Address — City	Y	City	Anytown
1	Billing Provider Address — State	Y	State abbreviation	VA
1	Billing Provider Address — ZIP Code	Y	U.S. Postal ZIP code (9 digits)	12345-0001
1	Billing Provider Phone	O	Area code plus phone number (10digits)	757-555-4444
1	Billing Provider Fax	O	Area code plus fax number(10 digits)	757-444-5555
1	Billing Country Code	N		
2	Provider Info/Pay-to Name	S	Facility name	123 Hospital System
2	Provider Info/Pay-to Street	S	Number and street	111 Somewhere St.
2	Provider Info/Pay-to City	S	City	Anytown
2	Provider Info/Pay-to State	S	State abbreviation	NC
2	Provider Info/Pay-to ZIP Code	S	U.S. Postal ZIP code	53211-0001
2	Provider Info/Pay-to Phone Number	O	Area code plus phone number (10digits)	
3a	Patient Control Number	S	Provider's control number for patient	123CNTL456
3b	Medical Record Number	S	Provider's medical record number forpatient	123REC456
4	Type of Bill	Y	Enter appropriate three-digit code fortype of bill	111
5	Federal Tax Number	Y	Valid 9-digit Tax ID or SSN	999887777
6	Statement Period From	Y	MMDDYY	021108
6	Statement Period To	Y	MMDDYY	021908
7	Local Use	N		
8a	Patient ID	Y	Member's Healthy Blue number orstate-assigned Medicaid number	123456789
8b	Patient Name	Y	Last name, first name, middle initial	Doe, John E.
9a	Patient Street	Y	Number and street	123 Somewhere St
9b	Patient City	Y	City	Anytown
9c	Patient State	Y	State abbreviation	VA
9d	Patient ZIP Code	Y	U.S. Postal ZIP code	12345
9e	ZIP Code+4	S		0001
10	Birth Date	Y	MMDDYY	070499
11	Sex	Y	F = Female, M = Male	M
12	Admission Date	S	MMDDYY	021108

UB-04				
Field #	**Field name**	**Required** Y = Yes N = No S = Situational	**Description format**	**Example**
13	Admission Hour	S	Enter admission hour	13
14	Admission Type	S	Enter valid admission type	01
15	Admission Source Code	S	Enter valid admission source code	07
16	Discharge Hour	S	Enter discharge hour	12
17	Status	S	Enter valid discharge status	01
18	Condition Code	S	Enter valid condition code	A9
19	Condition Code	S	Enter valid condition code	04
20	Condition Code	S	Enter valid condition code	M0
21	Condition Code	S	Enter valid condition code	
22	Condition Code	S	Enter valid condition code	
23	Condition Code	S	Enter valid condition code	
24	Condition Code	S	Enter valid condition code	
25	Condition Code	S	Enter valid condition code	
26	Condition Code	S	Enter valid condition code	
27	Condition Code	S	Enter valid condition code	
28	Condition Code	S	Enter valid condition code	
29	Accident State	S	State abbreviation	VA
30	Local Use	N		
31 a & b	Occurrence Code/Date	S	Enter valid occurrence code and thendate (MMDDYY)	a. 01 021108 b. 04 021108
32 a & b	Occurrence Code/Date	S	Enter valid occurrence code and thendate (MMDDYY)	a. 06 021108
33 a & b	Occurrence Code/Date	S	Enter valid occurrence code and thendate (MMDDYY)	
34 a & b	Occurrence Code/Date	S	Enter valid occurrence code and thendate (MMDDYY)	
35 a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and thendate (MMDDYY)	a. 72 021108 021108
36 a & b	Occurrence Span Code/From/Through	S	Enter valid occurrence code and thendate (MMDDYY)	
37	Local Use	N		
38	Payer Name and Address	S	Enter the claims submission address	Blue Cross NC | Healthy Blue P.O. Box 11111-1111 Virginia Beach, VA 23462
39 a	Value Code/Amount	S	Enter valid value code and amount*	73 20 00
39 b	Value Code/Amount	S	Enter valid value code and amount*	D3 45 00
39 c	Value Code/Amount	S	Enter valid value code and amount*	54 30
39 d	Value Code/Amount	S	Enter valid value code and amount*	
40 a	Value Code/Amount	S	Enter valid value code and amount*	
40 b	Value Code/Amount	S	Enter valid value code and amount*	
40 c	Value Code/Amount	S	Enter valid value code and amount*	

UB-04				
Field #	**Field name**	**Required** Y = Yes N = No S = Situational	**Description format**	**Example**
40 d	Value Code/Amount	S	Enter valid value code and amount*	
41 a	Value Code/Amount	S	Enter valid value code and amount*	
41b	Value Code/Amount	S	Enter valid value code and amount*	
41c	Value Code/Amount	S	Enter valid value code and amount*	
41d	Value Code/Amount	S	Enter valid value code and amount*	
42	Revenue Code	Y	Enter valid revenue code	0450
43	Description	O		
	* Note: All newborn claims should contain a value code of 54 — Newborn birth w eight in grams, along with the birthw eight of the baby.			
44	HCPCS/Rates	S	Enter valid HCPCS/Rate/ HIPPS code	99284
45	Service Date	S	MMDDYY	021108
46	Service Units	Y	Enter number of units	1
47	Total Charges	Y	Enter total charges for line	500 00
48	Non-Covered Charges	N		
49	Local Use	N		
42–23	PAGE _ OF _	O	Enter page counts	1 OF 1
42–23	CREATION DATE	O	Enter date claim was created	21208
42–23	TOTALS →	O	Enter total charges for the claim	
50 a	Payor Name	Y	Enter the primary payer name	Blue Cross NC
50 b	Payor Name	S	Enter the secondary payer name	For All Commercial Ins
50 c	Payor Name	S	Enter the tertiary payer name	
51 a	Health Plan ID	N		
51 b	Health Plan ID	N		
51 c	Health Plan ID	N		
52 a	Rel Info	Y	Indicate *Release of Information* statement on file	Y
52 b	Rel Info	S		
52 c	Rel Info	S		
53 a	Assign Benefits	N		
53 b	Assign Benefits	N		
53 c	Assign Benefits	N		
54 a	Prior Payments	S	Enter any prior payments	300 00
54 b	Prior Payments	S	Enter any prior payments	
54 c	Prior Payments	S	Enter any prior payments	
55 a	Est. Amount Due	S	Enter estimate amount due from patient	15 00
55 b	Est. Amount Due	S		
55 c	Est. Amount Due	S		
56	NPI	Y	Valid 10-digit NPI number	9871234567
57 a	Other Provider ID	Y	Appropriate and valid qualifier and provider ID number: Taxonomy	ZZ282NC2000X

UB-04				
Field #	**Field name**	**Required** Y = Yes N = No S = Situational	**Description format**	**Example**
57 b	Other Provider ID	S	Appropriate and valid qualifier and provider ID number: Medicaid	1D 345678
57 c	Other Provider ID	S	Appropriate and valid qualifier and provider ID number: Healthy Blue ID	
58 a	Insured's Name	S	Last name, first name, middle initial	Doe, John, E.
58 b	Insured's Name	S	Last name, first name, middle initial	
58 c	Insured's Name	S	Last name, first name, middle initial	
59 a	Patient Relationship	R	Enter a valid patient relationship code	19
59 b	Patient Relationship	R	Enter a valid patient relationship code	18
59 c	Patient Relationship	R	Enter a valid patient relationship code	
60 a	Insured's Unique ID	Y	Member's Healthy Blue number including the alpha prefix	GJN123456789
	Insured's Unique ID	S	Insured unique identification number	23234545
60 c	Insured's Unique ID	S		
61 a	Group Name	S	Enter group name	Medicaid
61 b	Group Name	S	Enter group name	For All Commercial Ins
61 c	Group Name	S	Enter group name	
62 a	Insurance Group Number	S	Enter group number	
62 b	Insurance Group Number	S	Enter group number	F32415G
62 c	Insurance Group Number	S	Enter group number	
63 a	Treatment Authorization Code	S	If authorization was obtained for services, enter the auth code given	1234AUTH5678
63 b	Treatment Authorization Code	S	If authorization was obtained for services, enter the auth code given	
63 c	Treatment Authorization Code	S	If authorization was obtained for services, enter the auth code given	
64 a	Document Control Number	N		
64 b	Document Control Number	N		
64 c	Document Control Number	N		
65 a	Employer Name	S	Enter employer name	Some Bank Name Inc
65 b	Employer Name	S	Enter employer name	
65 c	Employer Name	S	Enter employer name	
66	DX Indicator	N	Enter diagnosis qualifier	9
67	Principal Diagnosis Code	Y	Enter valid diagnosis code	821.3
67 a	Other diagnosis code A	S	Enter valid diagnosis code	733.93
67 b	Other diagnosis code B	S	Enter valid diagnosis code	531
67 c	Other diagnosis code C	S	Enter valid diagnosis code	
67 d	Other diagnosis code D	S	Enter valid diagnosis code	
67 e	Other diagnosis code E	S	Enter valid diagnosis code	
67 f	Other diagnosis code F	S	Enter valid diagnosis code	
67 g	Other diagnosis code G	S	Enter valid diagnosis code	

UB-04				
Field #	**Field name**	**Required** Y = Yes N = No S = Situational	**Description format**	**Example**
67 h	Other diagnosis code H	S	Enter valid diagnosis code	
67 i	Other diagnosis code I	S	Enter valid diagnosis code	
67 j	Other diagnosis code J	S	Enter valid diagnosis code	
67 k	Other diagnosis code K	S	Enter valid diagnosis code	
67 l	Other diagnosis code L	S	Enter valid diagnosis code	
67 m	Other diagnosis code M	S	Enter valid diagnosis code	
67 n	Other diagnosis code N	S	Enter valid diagnosis code	
67 o	Other diagnosis code O	S	Enter valid diagnosis code	
67 p	Other diagnosis code P	S	Enter valid diagnosis code	
67 q	Other diagnosis code Q	S	Enter valid diagnosis code	
68	Local Use	N		
69	Admit Diagnosis Code	Y	Enter valid diagnosis code	733.93
70 a	Patient Reason DX A	S	Enter valid diagnosis code	346.2
70 b	Patient Reason DX B	S	Enter valid diagnosis code	
70 c	Patient Reason DX C	S	Enter valid diagnosis code	
71	PPS Code	S	Enter valid disease-related group code	123
72 a	ECI A	S	Enter valid diagnosis code	E812
72 b	ECI B	S	Enter valid diagnosis code	
72 c	ECI C	S	Enter valid diagnosis code	
73	Local Use	N		
74	Principal Procedure Code	S	Enter valid procedure code	0032
74	Principal Procedure Date	S	MMDDYY	021108
74 a	Other Procedure Code	S	Enter valid procedure code	
74 a	Other Procedure Date	S	MMDDYY	
74 b	Other Procedure Code	S	Enter valid procedure code	
74 b	Other Procedure Date	S	MMDDYY	
74 c	Other Procedure Code	S	Enter valid procedure code	
74 c	Other Procedure Date	S	MMDDYY	
74 d	Other Procedure Code	S	Enter valid procedure code	
74 d	Other Procedure Date	S	MMDDYY	
74 e	Other Procedure Code	S	Enter valid procedure code	
74 e	Other Procedure Date	S	MMDDYY	
75	Local Use	N		
76	Attending NPI	S	Valid 10-digit NPI number	2323232323
76	Attending Qualifier	S	Use corresponding qualifier for ID number submitted in 76: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
76	Attending ID	S	Appropriate and valid provider ID: Medicaid, Blue Cross NC, Tax ID or SSN	444556666
76	Attending Last Name	S	Attending physician's last name	Doe
76	Attending First Name	S	Attending physician's first name	Robert

UB-04				
Field #	**Field name**	**Required** Y = Yes N = No S = Situational	**Description format**	**Example**
77	Operating NPI	S	Valid 10-digit NPI number	2121212121
77	Operating Qualifier	S	Use corresponding qualifier for ID number submitted in 77: G2= Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
77	Operating ID	S	Appropriate and valid provider ID: Medicaid, Blue Cross NC, Tax ID or SSN	123456789
77	Operating Last Name	S	Operating physician's last name	Smith
77	Operating First Name	S	Operating physician's first name	Jane
78	Other (Space)	S	Enter qualifier for the provider reported:DN — Referring, ZZ — Other Operating Physician or 82 — Rendering Provider	82
78	Other NPI	S	Valid 10-digit NPI number	1112223334
78	Other Qualifier	S	Use corresponding qualifier for ID number submitted in 78: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	EI
78	Other ID	S	Appropriate and valid provider ID; Medicaid, Blue Cross NC, Tax ID or SSN	987654321
78	Other Last Name	S	Physician's last name	Jones
78	Other First Name	S	Physician's first name	Jack
79	Other NPI	S	Valid 10-digit NPI number	
79	Other Qualifier	S	Use corresponding qualifier for ID number submitted in 79: G2 = Healthy Blue number, 1D = Medicaid, EI or 24 = Tax ID, 34 = SSN	
79	Other ID	S	Appropriate and valid provider ID: Medicaid, Blue Cross NC, Tax ID or SSN	
79	Other Last Name	S	Physician's last name	
79	Other First Name	S	Physician's first name	
80	Remarks	S	Enter any free form remarks	Sample claim — Not Valid
81 a	CC	N		
81 b	CC	N		
81 c	CC	N		
81 d	CC	N		

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