SECTION 3
TIME RESTRICTED SUPPLEMENT

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PROVIDER MANUAL SUPPLEMENT

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INTRODUCTION

In response to the guidelines set forth by the Centers for Medicare and Medicaid Services (CMS), the South Carolina Department of Health and Human Services (SCDHHS) will begin implementation of the new National Drug Code (NDC) billing requirement, revised (08-05) CMS-1500 claim form, and the National Provider Identifier (NPI) and Taxonomy Code effective January 1, 2007.

Important Dates

Here are the important implementation dates for NDC, CMS-1500 revised claim form, and NPI:

DATE	FILING/BILLING REQUIREMENTS
January 1, 2007	⦿ **NDC: <u>Mandatory</u>** use of the revised CMS-1500 claim form when billing drug-related procedure codes for dates of service on and after January 1, 2007.
January 1, 2007 through March 31, 2007	⦿ **<u>Optional</u>** use of the revised CMS-1500 claim form, except when billing drug-related procedure codes (see above). ⦿ **<u>Optional</u>** use of NPI - Providers who have obtained a National Provider Identifier (NPI) should utilize their NPI along with their six-character Medicaid Provider ID as soon as possible to ensure a smooth transition.
April 1, 2007	⦿ **<u>Mandatory</u>** use of the revised CMS-1500 claim form for billing and rebilling.
May 23, 2007	⦿ **<u>Mandatory</u>** use of the NPI – legacy numbers (i.e., the six-character Medicaid Provider ID) will no longer be accepted. **(Unless an atypical service provider)**

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NATIONAL DRUG CODE

An NDC is an 11-digit code unique to a manufacturer and a specific drug or product. Providers will be required to begin using their NDC codes with all drugs administered in an office/clinic or other outpatient setting with dates of service on and after January 1, 2007. Providers billing drug-related Health Common Procedure Coding System (HCPCS) codes will also be required to use the revised CMS-1500 claim form beginning January 1, 2007. For more information on the revised CMS-1500 claim form**,** see the *CMS-1500 Claim Form* section of this supplement. SCDHHS will require providers billing for prescription drug products administered in an office or outpatient setting using a drug-related HCPCS code to include the following information on all filing documents:

- **NDC**-11-digit code in 5-4-2 format
- **Quantity of each submitted NDC**- The quantity of each submitted NDC, which must be a numeric value greater than zero, should also be submitted on the claim.
- **Unit of measurement (UOM) for each submitted NDC**- The unit of measurement (UOM) is also required for each NDC. The table below lists valid codes for the UOM.

o F2 (international unit)	o ML (milliliter)
o GR (gram)	o UN (unit)

Example: If the billing unit value is IU (international unit), submit F2 as the UOM.

CLAIMS SUBMISSION REQUIREMENTS

As mentioned earlier, an 11-digit NDC code is required for proper claims submission. The NDC code follows a 5-4-2 format (*i.e.*, 5-digits, followed by 4-digits, followed by 2-digits using no hyphens or spaces). Many NDCs are displayed on drug packaging in a 10-digit format. In order to convert a 10-digit NDC to 11-digits, providers must use a leading "0" to fill the missing digit. The correctly formatted additional "0" is shaded in the following example. **Please note that hyphens and spaces are used solely to illustrate the various formatting examples for NDCs. Do not use hyphens when entering actual data.**

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example
4-4-2	9999-9999-99	5-4-2	09999-9999-99
5-3-2	99999-999-99	5-4-2	99999-0999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-09

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BILLING AND FILING REQUIREMENTS

The new NDC billing information is required for providers billing for prescription drugs administered in an office/clinic, infusion center, or other outpatient non-institutional setting. NDC fields should be completed on the revised CMS-1500 claim form as well as all electronic transactions such as clearinghouses and the South Carolina Medicaid Web-based Claims Submission Tool. NDC should not be used for drugs rendered in a home or nursing home. The new NDC billing requirements are also required for claims filed with the drug-related HCPCS/CPT codes such as J-codes, K-codes, and Q-codes.

Note: Providers may be required to update their individual software programs to include the new NDC fields. For assistance with correctly populating the supporting NDC fields, Palmetto Government Benefits Administrators (GBA) maintains an NDC to HCPCS Crosswalk at http://www.palmettogba.com (search for "NDC").

CLAIM FILING GUIDELINES

Electronic Claims

The required data for the 837-P transaction are part of the 2410 Loop-Drug Identification.

The LIN segment for Item Identification includes these required data elements:

- The qualifier: **N4 (LIN02)**
- **NDC**-All numeric **11-digit code** (no hyphens or spaces) **(LIN03)**

Here is an example of what the segment should look like: **LIN**N4*01234567892~**

The **CTP** segment for Drug Pricing Information includes these required data elements:

- **NDC Unit Price**- Entry into this field should be **0.00** for $0.00 **(CTP03)**
- **NDC Units** value (maximum length of 15)

  ***SCDHHS recommends maximum character length of thirteen (13), including decimal point "."** The numeric value for the quantity will not necessarily be a whole number; when a "decimal" quantity is administered, then that fractional quantity (e.g., 0.5) must be submitted. Following are various examples. **(CTP04)**

Examples:

12.375
12
0.5
123456789
100000000.375

Qualifier: **NDC Unit of Measurement**-Valid codes include: **UN, F2, ML, GR (CTP05-1)**

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Segment Examples: **CTP***0.00*2*UN~ **CTP***0.00*0.5*GR~**

Please refer to the S.C. Medicaid Companion Guides for information regarding the placement of NDC information on an electronic claim. The guides are located at: http://www.scdhhs.gov./dhhsnew/hipaa/Companion_Guides.asp.

Web Tool

The required entry fields on the Web Tool are:

- NDC
- Units (Quantity)
- Unit of Measurement (UOM).
- **NDC-** All numeric **11-digit code** (no hyphens or spaces)
- **NDC Units** value- Maximum length of thirteen (13), including the decimal point "." with the whole number portion having a maximum length of nine (9) and the decimal portion having a maximum length of three (3). Following are various examples.

  Note: No decimal required with the whole number.

Examples:

12.375
12
0.5
123456789
100000000.375

NDC Unit of Measurement-Length of two (2) bytes with valid codes to include: **UN, F2, ML, GR**

The required NDC fields will be placed on the detail line entry screen. For the translator, unit price is required. This value will be set to $0.00 by the Web Tool program for the translator. (No entry is required by the provider.)

Please refer to the Web Tool User Guide at www.scmedicaidprovider.org (click on SC Medicaid Web-based Claims Submission Tool).

Hard Copy Claims

SCDHHS will only accept hard copy claims submitted on the revised CMS-1500 (08-05 version) with effective dates of service beginning on or after January 1, 2007 when a procedure code for a drug administered in an office/clinic or outpatient setting is billed. When such a procedure code is entered in box 24D (unshaded area), a corresponding **11-digit NDC number** must also be indicated on the claim (shaded area). The six service lines in section 24 have been divided

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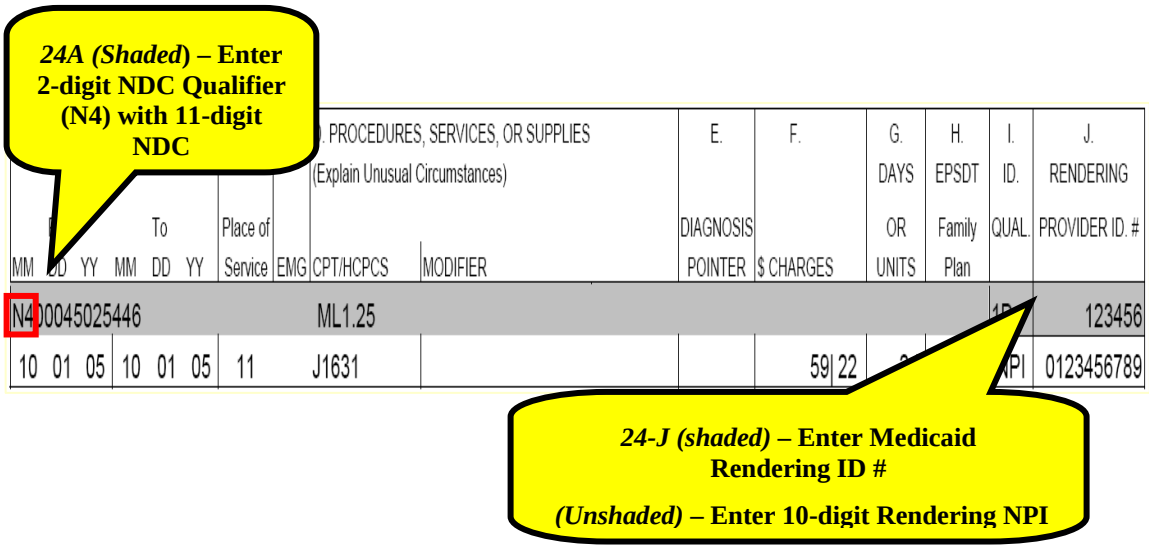
horizontally to accommodate submission of both the National Provider Identifier (NPI) and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information (*e.g.*, NDC number[s]) to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. **It is not intended to allow the billing of 12 lines of service**. The NDC number-related data is to be placed in the shaded sections of 24A and 24D. The qualifier **N4** must precede the NDC number. Refer to the example below:



Please complete the following boxes as described below when billing for drug-related codes on the CMS-1500 (08-05 version):

- **Box 24A:**
  - Shaded area: Enter the NDC qualifier of **N4**, followed by an 11-digit NDC number. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. **The NDC number being submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.**
  - Unshaded area: Enter the date(s) of service.
- **Box 24B:**

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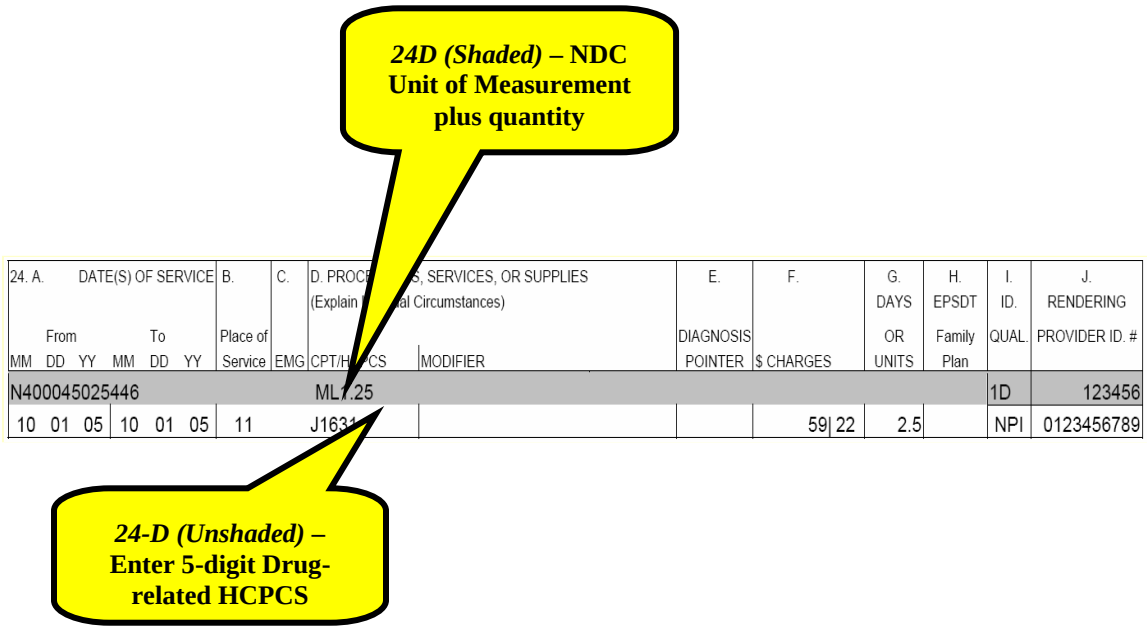
- Unshaded area: Enter the appropriate two-digit code from the place of service code list for each item used or service performed.

- **Box 24C:**
  - Unshaded area: Determine if this element (Emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO." Emergencies are defined by federal or state regulations, programs, or payer contracts.

- **Box 24D:**
  - Shaded area: Enter the NDC unit of measurement and numeric quantity administered to the patient. Enter the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The maximum number of bytes allowed for the quantity is 13, including the decimal point. Nine numbers may precede the decimal point and three numbers may follow the decimal. The unit of measurement codes and a sample claim are included below.

  - Unshaded area: Enter the HCPCS code and a corresponding 2-character modifier (if applicable).



- **Box 24E:** Not applicable

- **Box 24F:**
  - Unshaded area: Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.

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- **Box 24G:**
  - Unshaded area: If applicable, enter the days or units provided for each procedure listed.

A sample of the revised CMS-1500 claim form (08-05 version) is included in *Sample Forms* at the end of this supplement.

NDC EDIT CODES

There are four new edits associated with NDC fields that are not populated or contain invalid information. See an example Edit Correction Form (ECF) in *Sample Forms*

1. **Edit 202 (missing NDC)**

   If there is no 11-digit NDC entered in 24A (shaded), the line will reject. The NDC(s) for the HCPCS code(s) submitted must be the actual NDC number listed on the medication package or container.

2. **Edit 301 (Invalid NDC)**

. NDC(s) for the HCPCS code(s) submitted must be the actual NDC number listed on the medication package or container. However, the NDC must be properly formatted to 11 digits if the NDC on the package is only 10 digits. If the 11-digit NDC is invalid, the line will reject.

3. **Edit 203 (NDC unit/quantity missing)**

   For each NDC submitted, the NDC quantity is required. If the NDC quantity is missing, the line will reject. The NDC quantity must be a numeric value that is greater than zero.

Note: In most cases, the NDC quantity will be different from the HCPCS billed units. To determine the correct NDC quantity, use the data column titled CF (conversion factor) on the NDC to HCPCS Crosswalk. Divide the number of billed HCPCS units by the CF. Enter the resulting number as the NDC Quantity. [The formula is: HCPCS units divided by CF= NDC Quantity.]

4. **Edit 204 (NDC Unit of Measurement missing/invalid)**

   For each valid NDC submitted, a valid UOM code is required. If the NDC UOM is missing, the line will reject. Use the table above to ensure the correct UOM is being used.

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NDC TO HCPCS CROSSWALK

To assist in locating the HCPCS that you should file, a NDC crosswalk is available. Resources for electronic claims are located in the Companion Guides. The Companion Guides can be found at **www.scdhhs.gov**. HCPCS for hardcopy claims can be found in the CMS-1500 Completion Guide at **www.scmedicaidprovider.org** and/or your provider manual at **www.scdhhs.gov**. The Web Tool User Guide is also a valuable resource, as it will be updated along with the Web Tool.

CMS-1500 CLAIM FORM

SCDHHS is implementing the revised CMS-1500 form (08-05) effective **January 1, 2007** in response to the guidelines set forth by CMS. Although the revised version will be effective January 1, 2007, use of the form is optional until **April 1, 2007, unless you are billing using NDC codes**. Providers billing for drugs administered in an office/clinic or other outpatient non-institutional setting with dates of service on and after January 1, 2007, are **mandated** to use the revised form to report NDC numbers. The transitional dual acceptability period of the current and the revised form is described as follows:

- **January 1, 2007-March 31, 2007**: Providers can use either the current form CMS-1500 (12-90) version or the revised form CMS-1500 (08-05) version.

- **April 1, 2007**- The current form CMS-1500 (12-90) will be discontinued; only the revised form CMS-1500 (08-05) is to be used. All rebilling of claims should use the revised form from this date forward even though earlier submissions may have been on the current CMS-1500 (12/90).

CURRENT VS. REVISED CMS-1500

A major difference between form CMS-1500 (08-05) and the prior form is the provision for split provider identifier fields. The split fields enable NPI reporting in the fields labeled NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field. Some of the other changes include:

- Additional fields added- NPI and NDC (24a-24j)
- Fields 32 and 33 (Service Facility Location Information, Billing Provider Information and Phone)
- New filing method for prescription drugs administered in office or outpatient setting

NPI on the Revised CMS-1500 claim form

All individuals and organizations who meet the definition of a health care provider as described at 45 CFR 160.103 are eligible to obtain an NPI. If you are one of these

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providers, Medicaid considers you a Typical provider. If you do not meet the definition of a health care provider, Medicaid considers you an Atypical provider (*i.e.* non-emergency transportation, personal care aid, foster care, etc.) If you are an Atypical provider, you should continue to bill Medicaid under your existing six-digit Medicaid (legacy) provider ID number in boxes 24J, 32b, and 33b when required. If you are a Typical provider, you should bill Medicaid with your 10-digit NPI provider number in the designated NPI boxes 24J, 32b, and 33b when required.

How To Complete SC Medicaid Required Fields

Please refer to the following table for key changes that will affect the Medicaid billing:

Changes to the CMS-1500 Health Insurance Claim Log	
*Required for claim to process **Required if applicable **(based upon the specific program area requirements)**	
Location	**Change**
17a	Not applicable
17b	Not applicable
19**	If applicable, this box should be used for beneficiaries participating in special programs (i.e., Medical Homes, PEP, Hospice, etc) when a referral number is issued by the primary care provider.
21*	The lines after the decimal point in boxes 1, 2, 3, and 4 were extended to accommodate four bytes.
23**	If applicable, enter the prior authorization number for the claim.
24	The line with the alpha indicators was removed. The alpha indicators were moved next to the respective title in the title fields. Each of the six lines was split lengthwise and shading was added to the top portion of each line. This area is to be used for the reporting of supplemental information.
24A – Shaded**	Enter the NDC qualifier of N4, followed by an 11-digit NDC number. Do not enter a space between the qualifier and the NDC. See example below:

24. A. DATE (S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E.	F.		G.	H.	I.	J.
From MM	DD	YY	To MM	DD	YY	Place of Service	EMG	CPT/HCPS	MODIFIER	DIAGNOSIS POINTER	$CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID.#
N400045025446								ML1.25							1D	123456
01	01	07	01	01	07	11		J1631			59	22	2.5		NPI	123456789

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Changes to the CMS-1500 Health Insurance Claim Log	
*Required for claim to process **Required if applicable **(based upon the specific program area requirements)**	
Location	**Change**
24A–Unshaded*	Enter the month, day and year for each procedure, service, or supply.
24B–Unshaded*	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.
24C**	"Type of Service" was removed. This field is now titled "EMG." Leave blank if not an emergency; enter "Y" if an emergency.
24D	The field became wider by three bytes. Shading was added vertically between "CPT/HCPCS" and "MODIFIER."
24D–Shaded area**	Enter the NDC unit of measurement and numeric quantity administered to the patient. Enter the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. Maximum number of bytes allowed for the quantity is 13, including the decimal point. Nine numbers may precede the decimal point and 3 may follow the decimal. (Refer to Medicaid Bulletin dated 9/11/06 regarding NDC Billing Requirements.)
24D–Unshaded area*	Enter the procedure code and, if applicable, the two-digit modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted procedures, an attachment with a description of each procedure must be included with the claim.
24E	Not Applicable
24F–Shaded area**	Enter the NDC Unit Price if known. The NDC unit price must be a numeric value. If the unit price is not known, submit a value of $0.00.
24F–Unshaded area*	Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
24G–Unshaded area**	If applicable, enter the days or units provided for each procedure listed.
24H–Unshaded area**	If this claim is for EPSDT services or a referral from an EPSDT Screening, enter a "Y."
24I	The title was changed from "EMG" to "ID. QUAL."

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<table>
<tr><th colspan="3">Changes to the CMS-1500 Health Insurance Claim Log</th></tr>
<tr><td colspan="3">*Required for claim to process
**Required if applicable (based upon the specific program area requirements)</td></tr>
<tr><th>Location</th><th colspan="2">Change</th></tr>
<tr><td rowspan="2">24I– Shaded area</td><td>Typical Providers</td><td>Atypical Providers</td></tr>
<tr><td>January 1, 2007 – May 22, 2007: Enter 1D for the Medicaid qualifier.
May 23, 2007 and after: Enter ZZ for the taxonomy qualifier.</td><td>January 1 and after: Enter two- byte qualifier 1D for Medicaid.</td></tr>
<tr><td>24I – Unshaded</td><td colspan="2">The label “NPI” was added.</td></tr>
<tr><td rowspan="2">24J– Shaded**</td><td>Typical Providers</td><td>Atypical Providers</td></tr>
<tr><td>January 1, 2007 – May 22, 2007: Enter the current Medicaid Provider ID Number. May 23, 2007 and after: Enter the Provider taxonomy code.</td><td>January 1 and after: Enter the 6- digit Medicaid Provider ID Number.</td></tr>
<tr><td>24J – Unshaded**</td><td colspan="2">The title was changed from “COB” to “RENDERING PROVIDER ID. #.” The NPI number of the rendering individual provider may be entered here. If the provider is billing as a member of a group, the rendering individual provider’s 10-character NPI number may be entered. The rendering individual provider’s NPI may be reported as early as January 1, 2007; it must be reported on and after May 23, 2007.</td></tr>
<tr><td>24K</td><td colspan="2">This field was removed.</td></tr>
<tr><td>32**</td><td colspan="2">Enter the name, address, and ZIP+4 code of the facility if the services were rendered in a facility other than the patient’s home or provider’s office.</td></tr>
<tr><td>32a**</td><td colspan="2">Enter the NPI of the service facility as soon as it is available. The NPI may be reported as early as January 1, 2007, and must be reported on and after May 23, 2007.</td></tr>
<tr><td rowspan="2">32b **</td><td>Typical Providers</td><td>Atypical Providers</td></tr>
<tr><td>Prior to May 23, 2007 enter the two-byte qualifier 1D followed by the Medicaid Provider (Legacy) ID number (no spaces). On and after May 23, 2007, enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).</td><td>January 1 and after – enter the two-byte qualifier 1D followed by the Medicaid Provider (Legacy) ID number (no spaces).</td></tr>
</table>

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<table>
<tr><th colspan="3">Changes to the CMS-1500 Health Insurance Claim Log</th></tr>
<tr><td colspan="3">*Required for claim to process
**Required if applicable (based upon the specific program area requirements)</td></tr>
<tr><th>Location</th><th colspan="2">Change</th></tr>
<tr><td>33*</td><td colspan="2">Enter the provider of service/supplier’s billing name, address, ZIP+4 code, and telephone number. Do not use commas, periods, or other punctuation in the address. When entering a 9-digit zip code (ZIP+4), include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in box 33 of the CMS-1500 form. This pay-to-provider number is indicated on the Remittance Advice and check.</td></tr>
<tr><td>33a*</td><td colspan="2">Effective May 23, 2007, you MUST enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a member of a group, enter the 10-character individual NPI number in this box. The NPI may be reported as early as January 1, 2007.</td></tr>
<tr><td rowspan="2">33b*</td><td>Typical Providers</td><td>Atypical Providers</td></tr>
<tr><td>The title was changed from “GRP#” to “b.” to accommodate the reporting of other ID numbers. Prior to May 23, 2007, enter the two-byte qualifier1D followed by the Medicaid Provider (Legacy) ID
number (no spaces).

On and after May 23, 2007, enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces). See example below:</td><td>January 1 and after – enter the two-byte qualifier 1D followed by the 6-digit Medicaid Provider ID number (no spaces).</td></tr>
</table>

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Changes to the CMS-1500 Health Insurance Claim Log	
*Required for claim to process **Required if applicable **(based upon the specific program area requirements)**	
Location	**Change**
	Typical Provider Example: 33. BILLING PROVIDER INFO & PH # (312) 5552222 Physician Practice Inc. 1234 Healthcare Street Anytown IL 60610-1234 a. 9876543210 b. ZZ208D00000X **Atypical Provider Example** 33. BILLING PROVIDER INFO & PH # (312) 5552222 Physician Practice Inc. 1234 Healthcare Street Anytown IL 60610-1234 a. b. 1D123456

NPI AND TAXONOMY CODES

The National Provider Identifier (NPI) is mandated as part of the Health Insurance Portability and Accountability Act (HIPAA) uniform health care identifier provisions. The NPI is a unique, all numeric, 10-digit number that will be used by covered health care providers in filing and processing electronic health care claims and other transactions. This 10-digit number replaces other identifiers such as your Medicaid, Medicare, BCBS, UPIN, TRICARE, and other payer provider numbers.

Effective May 23, 2007, SCDHHS will require the use of NPI instead of the South Carolina Medicaid provider number (legacy) on hard copy claims, standard electronic transactions including claims, claim status queries/responses, eligibility queries/responses, and remittance advices. Atypical providers do not need an NPI. Typical providers do need an NPI. Refer to the ***Current vs. Revised CMS-1500*** section of this supplement for information regarding Atypical and Typical providers. The transitional dual acceptability period of the current and the revised form is described as follows:

January 1, 2007-March 31, 2007:

- Providers billing drug-related procedure codes are required to use the revised CMS-1500 claim form for dates of service on and after January 1, 2007

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- During this time period, use of the revised CMS-1500 claim form is optional, for providers who bill non-drug codes.
- Providers who have obtained a NPI should utilize their NPI and Taxonomy code along with their six-character Medicaid Provider ID as soon as possible

April 1, 2007:

- The current form CMS-1500 (12-90) will be discontinued; only the revised form CMS-1500 (08-05) is to be used.

May 23, 2007:

- Use of the NPI is mandatory. Legacy numbers will no longer be accepted

TAXONOMY CODES

SCDHHS has identified the need to create a crosswalk from the NPI to the SC Medicaid provider number. Because some providers may choose to utilize the same NPI for multiple SC Medicaid provider numbers, SCDHHS requires a unique combination of NPI and taxonomy (chosen by the provider), for most current Medicaid provider numbers.

The taxonomy code is a unique 10-digit specialty code assigned under the HIPAA provisions to health care providers.

The taxonomy code is structured into three distinct levels including:

- Provider Type
- Classification
- Area of Specialization

This unique combination is required to accurately price and pay the provider's claims. To access the listing, go to

http://www.scdhhs.gov/internet/pdf/practicespecrosswalkbulletin090606.xls.

The taxonomy used on the claim must agree with the taxonomy the provider registers with SCDHHS. Providers may refer to the South Carolina Medicaid Companion Guides for information regarding placement of the NPI and taxonomy code. The Companion Guides are located at **www.scdhhs.gov**.

ENTITY 2 (ORGANIZATION PROVIDERS)

There are two unique specifications required for type 2 providers who want to get one NPI for multiple SC Medicaid provider IDs. A unique taxonomy code must be registered for each SC Medicaid provider number. If you are a provider that has multiple facilities at different locations, and all of your offices share the same NPI, SC Medicaid will require a different taxonomy code for each location.

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CONCLUSION

In order to ensure a smooth transition for NDC, CMS-1500, and NPI, it is important to read the resourceful information available to you and become familiar with the upcoming changes. Most importantly, being prepared and informed will ensure uninterrupted reimbursement.

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RESOURCES

National Drug Codes, CMS-1500, and NPI

Electronic Claims

- SC Medicaid Companion Guides
  - www.scdhhs.gov
    - Click on "Electronic Data Interchange"
    - Select "SC Medicaid Companion Guides"

Hardcopy Claims

- CMS-1500 Completion Guide
  - www.scmedicaidprovider.org

NDC to HCPCS Crosswalk

- www.palmettogba.com
  - Search for "NDC"
  - Click on the most current month listed
- Applicable Columns
  - HCPCS Description
  - Billing Units
  - CF (Conversion Factor)

CMS-1500 Completion Guide

- www.scmedicaidprovider.org

SC Medicaid Bulletins

- www.scdhhs.gov

Other Educational Web sites

- www.dhhs.sc.us/dhhsnew/serviceproviders/npiinfo.asp
- http://www.cms.hhs.gov/NationalProvIdentStand/04education.asp

Taxonomy Codes

- www.wpc-edi.com/taxonomy/more_information
  - List of frequently asked questions
  - Email: taxonomy@wpc-edi.com

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SAMPLE FORM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

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

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

RUN DATE 11/30/2006 0000 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0700400001810000A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 1 ECF 1 PAGE 1 OF 1
ANALYST ID HIC - 21 PRAC SPEC - 55 EMC Y
SIGNON ID CLAIM RESTART DATE / / DOC IND N

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 ---- DIAGNOSIS ---- PRIMARY	SECONDARY
GP1234	1234567890						625.9	.

10 RECIPIENT NAME - Jane Doe 11 DATE OF BIRTH 05/29/1971 12 SEX F

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS	23 NDC	24 NDC UNIT QUAL	25 NDC UNITS
	.00	1	01/01/07	11	J1631	000	J1885		59.22	2.500	00045025446	ML	1.25
		2	/ /										
		3	/ /										
		4	/ /										
		5	/ /										
		6	/ /										
		7	/ /										
		8	/ /										

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 852

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**********************************
**    AGENCY USE ONLY           **
**     APPROVED EDITS           **
**                              **
**   REJECTED LINE EDITS        **
**                              **
**********************************
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!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
!  CLAIMS/LINE PAYMENT INFO    !
!                              !
!  EDIT        PAYMENT DATE    !
!  01-852        09/29/06      !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
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26 INS CARR NUMBER	27 POLICY NUMBER	28 INS CARR PAID		
01			29 TOTAL CHARGE	59.22
02			30 AMT REC'D INS	
03			31 BALANCE DUE	59.22
			32 OWN REF #	1000

RESOLUTION DECISION ___
ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
ABC RADIOLOGISTS PA
PO BOX 11111
ANYWHERE SC 12345-1234

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM