DIVISION OF
# Health Care
# Finance and Policy

*June 25, 2012*

# 837 Health Care Claim: Institutional

# MMIS Claims Migration Billing Guide

# Table of Contents

**Introduction**

Line item 4100-0060 of the state fiscal year 2012 budget within Chapter 68 of the Acts of 2011 (Chapter 68), requires the Division of Health Care Finance and Policy (the Division) to transition the processing of Health Safety Net (HSN) claims to MassHealth's MMIS claims system. Chapter 68 requires the Executive Office of Health and Human Services (EOHHS) to work with the Division to complete this transition as soon as feasible but not later than June 30, 2012.

**Purpose of the Billing Guide**

The Billing Guide outlines use of specific segments and data elements within those segments that are required for processing of HSN claims. Providers should review this document in its entirety to ensure accurate billing of HSN claims.

> *Note:   Unless otherwise noted in this billing guide, claims processing and adjudication will occur in accordance with MassHealth's 5010 specifications, companion guide and billing requirements.*

**Intended Audience**

The intended audience for this document is all staff responsible for generating, receiving and reviewing electronic health care transactions.

**Claims Submission:**

Providers will use the current MassHealth Provider Online Service Center (POSC) to upload claim files to HSN. Upon issuance of a new HSN Provider ID/service location, providers may access the POSC to submit files, and download file acknowledgements, 835s and RAs. MMIS will issue HSN provider ids. HSN will email the ids to providers during the week of May 21 or May 28. MMIS will copy over providers' security / access setup for these new ids so providers will not have to do this.

New HSN IDs will be populated in the same loops and segments as a MassHealth claim:

EDI Control Segment ISA06 - Interchange Sender ID
        (As long as the provider is the sender, otherwise use sender's ID)
EDI Control Segment GS02 - Application Sender's Code
        (As long as the provider is the sender, otherwise use sender's ID)
Loop 1000A:NM109 - Submitter Name - Identification Code
        (As long as the provider is the submitter, otherwise use submitter's ID)

**Direct Data Entry**

Direct Date Entry (DDE) will not be available for HSN Claims processing for the July 1, 2012 timeline. The Division will notify providers once DDE functionality is in place.

## Claims Operation Support

MassHealth's CST will provide support for processing of all HSN claims. Providers should forward all HSN claim inquiries to the CST at (855) 253-7717 or edi@mahealth.net except as noted below –

> *Inquiries on claim pricing, payment and eligibility should be forwarded to the Division's Claims Customer Support Center at (866) 697-6080 or HSNHelpLine@Uhealthsolutions.org.*

## 90-Day Waiver Procedures

A revised 90-day waiver request form is available for downloading at http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/90-dwr.pdf. The form and supporting documentation may be scanned and emailed to EHSHSN@state.ma.us.

Providers must submit the claim portion of their 90-day waiver first. 90-day waiver requests will initially appear in a suspended status on the remittance advice with Edit 818 (Special Handling 90-day waiver) and an ICN. The ICN must then be added to the supporting documentation sent to the email address above.

One of the following delay reason codes must be used in Loop 2300 CLM20 when submitting 90-day waiver requests:

1 - Proof of Eligibility Unknown or Unavailable
4 - Delay in Certifying Provider
8 - Delay in Eligibility Determination

If your claim requires a 90-day waiver for reasons other than 1 or 4, please use delay reason code 8 and explain the reason for the delay. Please note that the use of an incorrect delay reason code will cause claims to suspend for the incorrect edit and may subsequently cause the claims to deny.

90-day waiver decisions will be reflected when your claims appear processed on a subsequent remittance advice.

## Final Deadline Appeal Procedures

Final deadline appeal requests must be submitted with delay reason code 9 in Loop 2300 CLM20 of the 837 transaction. Please note that the use of an incorrect delay reason code will cause claims to suspend for the incorrect edit and may subsequently cause the claims to deny.

Providers must submit the claim portion of their appeals first. Final deadline appeal requests will initially appear in a suspended status on your remittance advice with Edit 828 (Claim/appeal is under review) and an ICN. The ICN must then be added to the supporting documentation sent to the email address above.

Failure to submit the required documentation with your appeal request may result in the denial of the appeal.

The decision resulting from the review will be reflected on a subsequent remittance advice. If the final appeal is denied, one of the following edit codes will appear with the claim:

9086 – Denied after review
9087 – Insufficient information
9088 – Duplicate appeal request
9089 – The request does not meet the criteria at 130 CMR 450.323(A)

Written notification of the approval or denial decision will be sent to the provider and constitutes the final agency action.

**Claim Pricing and Payment**

Health Safety Net providers will be required to submit their 837I (Institutional) and 837P (Professional) claims to MMIS as of July 1, 2012. MMIS will process and adjudicate all HSN claims based on existing MMIS edit / audit logic as well as additional HSN edits as outlined in this guide.

Processing of HSN claims by MMIS will result in providers receiving all information currently reported pursuant to MassHealth claims processing. This includes 835s and Remittance Advices (RA) that will be based on MassHealth's pricing rules.

> *Note:* With migration to MMIS, professional charges must be submitted on the 837P format (Version 5010) in accordance with MassHealth billing rules. Hospitals may submit professional charges to the HSN only when services are rendered by a hospital employed physician. Only physician services, as defined in the RFA, can be billed separately by hospitals for hospital based physicians on a professional claim form. Nurse practitioners, nurse midwives, physician assistants, social workers and other allied health professional are not hospital based physicians and should not be billed on a professional claim.
>
> For most hospitals, professional charges are not reimbursed separately as they are already accounted for within a provider's payment rate. Although providers will not be reimbursed separately for initial 837P submissions, claims data will be utilized for future payment calculations.

The HSN will continue to generate RAs detailing payments to be made. RAs will remain in the current format and will be downloaded directly from INET.

**Billing Identification Numbers**

HSN claims must be submitted with a correct provider billing NPI. Providers were asked to indicate which NPI would be used for billing of HSN claims. Claims submitted with an incorrect

billing NPI will result in claim denial. Providers with questions regarding their billing NPI should contact the MassHealth CST.

## HSN Site Org IDs

Providers must continue to report site of service information on all HSN claims. Site of service information will be provided via the same process as used by DHCFP where providers must code Loop 2310E; REF02 segment with the HSN assigned Site Org ID. *Note: MMIS assigned provider ids / service locations should not be reported in this field. Only HSN assigned site org ids will be allowed.*

Claims will be denied if the HSN Site Org ID is not provided or if the Site Org ID is not correct per DHCFP's filing hierarchy.

## Frequency Codes

HSN claims will only be accepted and processed based on the following claim frequency codes. Use of other codes will result in claims being denied.

> XX1 = Admit thru Discharge Claim
> XX7 = Replacement Claim
> XX8 = Void Claim

## Dummy Member Identification Numbers

Dummy member identification numbers (i.e, 000000001, 000000000001) will not be allowed as member identifiers in any field. If an SSN is unknown, the Subscriber Secondary Identification segment should be omitted.

## Carrier Codes

When a payer other than HSN is present, providers must report all other payers on a claim. The MassHealth Carrier Code List should be used to identify the specific code for a given payer. Providers should not utilize the HSN Payer Source Code List to identify codes for other payers. Providers with questions regarding carrier codes should contact the MassHealth CST.

Carrier Codes for auto insurance and worker's compensation claims will not be in place for July 1, 2012. As Direct Day Entry (DDE) will not be available for July 1, 2012, providers may submit these claims only without carrier codes. Auto insurance and worker's compensation claims will not be denied if carrier codes for another payer are present; however, providers should attempt to remove carrier codes as much as possible. Submission of claims without carrier codes or with carrier codes for another payer will only be allowed until such time that DDE or carrier codes for electronic claim submissions are in place.

Carrier code 7001 should be used for identification of MassHealth as another payer.

**Billing Deadlines**

Billing deadlines will be based on current MassHealth rules governing timely filing for HSN Prime, Secondary and Partial claims. HSN billing deadline requirements for Bad Debt (BD) claims will remain in place post claims migration. BD claims cannot be submitted earlier than 120 days from the date of service and must be submitted within 90 days of the date of write off.

As noted in Administrative Bulletin 12-17, billing deadlines will be waived for medical and professional claims submitted from July through December 2012 with dates of service of February 1, 2012 or later in order to accommodate any interruptions in claims processing during the transition period.

> *Note: Claims submitted after December 31, 2012 will be adjudicated based on customary billing deadline edits.*

Providers should contact the Division's Claims Customer Support Center at (866) 697-6080 or HSNHelpLine@Uhealthsolutions.org with questions regarding billing waiver timelines.

**Bad Debt Claims**

Providers will be required to meet evidence collection requirements as outlined in HSN regulations. Providers must complete the Evidence Collection Form on INET for Hospital Inpatient and Community Health Center BD claims in order for payment processing to occur.

To process Bad Debt claims, a referred eligibility process will occur where the HSN will report back to providers, via INET, an MMIS ID assigned to an individual that must be coded on a claim. Given that MMIS cannot process a claim without a member ID, providers must insure that initial bad debt claims (for members with no MMIS ID) must be submitted where 2010BA; NM102 = 2 and NM109 is blank. If an MMIS ID is present 2010BA; NM102 = 1 and NM109 is populated with the MMIS ID.

Where no MMIS ID is coded, the claim will deny; however, the Division will create a referred eligibility file that will generate assignment of an MMIS ID that will be reported back to the provider via INET. The bad debt claim can then be resubmitted with the assigned MMIS ID.

State/Zip or country codes must be provided within Loop 2010BA; N4 segment (Subscriber City / State / Zip Code) on all claims. If, after due diligence, a provider has been unable to determine this information, claim should be coded with the address (state/zip code) of the servicing facility.

Eligibility for individuals receiving BD services will not be reported via the Eligibility Verification System (EVS). Once an MMIS ID is assigned, members can be looked up in EVS via member id or name / date of birth.

Bad Debt claims for individuals whose contact information (name, date of birth, etc.) cannot be identified should not be submitted to MMIS. The Division is reviewing this matter internally and will follow up with providers in the near future.

**Medical Hardship & Confidential Applications**

The Division's Special Circumstances Application will continue to be utilized by providers for submission of applications for Medical Hardship (MH) and Confidential (CA) claims. MH & CA claims submitted without an application on file will not be processed for payment. Application ID's must be coded on MH & CA claims in accordance with current HSN requirements.

MassHealth claims cannot be processed unless submitted with a valid MMIS ID. To process MH & CA claims, a referred eligibility process will occur where the HSN will report back to providers, via INET, an MMIS ID assigned to an individual that must be coded on a claim. If a patient has an existing MMIS ID, providers should submit claim(s) (once the application has been approved) with the existing MMIS ID.

State/Zip or country codes must be provided within Loop 2010BA; N4 segment (Subscriber City / State / Zip Code) on all claims. If, after due diligence, a provider has been unable to determine this information, provider should code the address of the servicing facility.

Eligibility for MH & CA individuals will not be reported via the Eligibility Verification System (EVS). Once an MMIS ID is assigned, members can be looked up in EVS via member id or name / date of birth.

**Health Safety Net Estimated Amount Due (HSNEAD)**

The HSN requires an estimated amount due (HSNEAD) to process payments. HSNEAD will be derived based on data available within specific loops and segments.

Payment for Claims where HSN is Primary

> 837I claims where no other payer is present (SBR01 = P) and where claim type (SBR04) is Prime, Confidential or Medical Hardship: HSNEAD = Total Claim Charge Amount reported in Loop 2300, CLM02.
>
> 837I claims where no other payer is present (SBR01 = P) and where claim type (SBR04) is Partial: HSNEAD = Total Claim Charge Amount reported in Loop 2300, CLM02 _minus_ Patient Responsibility Amount reported in Loop 2300, AMT02 (where AMT01 = F3)*.
>
> 837I claims where no other payer is present (SBR01 = P) and where claim type (SBR04) is Bad Debt: HSNEAD = Total Claim Charge Amount reported in Loop 2300, CLM02 _minus_ Prior Patient Payment reported in Loop 2300, HI01-5 (where HI01-1 = BE & HI01-2 = FC).

Payment for Claims where HSN is not Primary

837I claims where another payer is present (SBR01 = value other than P) and where claim type (SBR04) is Second or Partial:

>HSNEAD = Total Claim Charge Amount reported in Loop 2300, CLM02 _minus_ Patient Responsibility Amount reported in Loop 2300, AMT02 (where AMT01 = F3)* _minus_ Payer Paid Amount reported in Loop 2320 (where AMT01 = D) _minus_ Prior payer's claim level adjustments reported in Loop 2320; CAS 03, CAS06, CAS 09, CAS 12, CAS 15, CAS 18 (Inpatient)

>HSNEAD = Total Claim Charge Amount reported in Loop 2300, CLM02 _minus_ Patient Responsibility Amount reported in Loop 2300, AMT02 (where AMT01 = F3)* _minus_ Payer Paid Amount reported in Loop 2320 (where AMT01 = D) _minus_ Prior payer's claim level adjustments reported in Loop 2320; CAS 03, CAS06, CAS 09, CAS 12, CAS 15, CAS 18 and Loop 2430; CAS 03, CAS 06, CAS 09, CAS 12, CAS 15, CAS 18 (Outpatient)

>* Lack of this AMT segment implies that providers have performed their due diligence and there is no Patient Responsibility Amount / patient deductible has been satisfied.

The following claim adjustment reason codes (CARCs) will not be billable to the HSN. Monetary amounts for these codes will be applied against a provider's total charges.

| Code | Description |
|------|-------------|
| 6 | The procedure/revenue code is inconsistent with the patient's age |
| 7 | The procedure/revenue code is inconsistent with the patient's gender |
| 13 | The date of death precedes the date of service. |
| 14 | The date of birth follows the date of service. |
| 15 | Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. |
| 18 | Duplicate claim/service |
| 24 | Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. |
| 29 | The time limit for filing has expired |
| 42 | Charges exceed our fee schedule or maximum allowable amount. |
| 44 | Prompt-pay discount. |
| 45 | Charges exceed your contracted/ legislated fee arrangement |
| 59 | Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. |
| 70 | Cost outlier - Adjustment to compensate for additional costs. |
| 92 | Claim paid in full. |
| 94 | Processed in excess of charges |
| 97 | Payment is included in the allowance for another service/procedure |
| 102 | Major Medical Adjustment |
| 104 | Managed care withholding |
| 110 | Billing date predates service date |

| 115 | Payment adjusted as procedure postponed or canceled. |
| 128 | Newborn's services are covered in the mother's allowance |
| 131 | Claim specific negotiated discount |
| 138 | Appeal procedures not followed or time limits not met |
| 140 | Patient/Insured health identification number and name do not match |
| 155 | This claim is denied because the patient refused the service/procedure |
| 158 | Payment denied/reduced because the service/procedure was provided outside of the United States |
| 189 | 'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure / service |
| 190 | Payment is included in the allowance for a Skilled Nursing Facility qualified stay |
| 226 | Info requested from Billing/Rendering Provider was not provided or insufficient/incomplete |
| 231 | Mutually exclusive procedures cannot be done in the same day/setting |
| 234 | Procedure is not paid separately |
| A2 | Contractual adjustment |
| A7 | Presumptive Payment Adjustment |
| B12 | Services not documented in patients' medical records |
| B13 | Previously paid. Payment for this claim/service may have been provided in a previous payment |

## Claim Adjustments / Voids

MassHealth rules require that claims must be coded with MassHealth assigned ICNs in order for adjustments or voids to be processed. HSN claims originally submitted to and processed by the Division will not contain ICNs. Providers seeking to submit adjustments or voids for these claims to MMIS must report in Loop 2300 within the REF segment an F8 qualifier in REF01 and the claim key assigned by the Division in REF02. Providers can identify the claim key for an HSN claim by reviewing their remit and looking under the column header of "K_CLM_02_130." MassHealth will utilize this information to assign an ICN that will be reported back to providers. Once an ICN is assigned, providers will be required to submit all adjustments / voids in accordance with MMIS requirements.

> *Note: Submission of the HSN claim key only applies to HSN paid claims originally processed by the Division and converted as part of migration. All other claims must be submitted in accordance with MMIS requirements.*

## Outlier Days

Billing of Outlier and Administrative Days must occur in accordance with the Health Safety Net's billing update of January 25, 2011. Billing updates are located on the HSN's web page.

## Split Eligibility

When providers are aware that an HSN Eligibility gap is present on a claim, billing must occur in accordance with the Health Safety Net's billing update of May 4, 2009. Billing updates are located on the HSN's web page.

## Unlisted Procedure Codes

837I claims submitted with unlisted procedure codes will be allowed only if submitted along with at least one HSN allowed procedure code that is not categorized as "unlisted" by CMS. Claims submitted with unlisted procedure codes only will be denied. Unlisted procedure codes include -

01999, 15999, 17999, 19499, 20999, 21089, 21299, 21499, 21899, 22999, 23929, 24999, 25999, 26989, 27299, 27599, 27899, 28899, 29799, 29999, 30999, 31299, 31599, 31899, 32999, 33999, 36299, 37501, 37799, 38129, 38589, 38999, 39499, 39599, 40799, 40899, 41599, 41899, 42299, 42699, 42999, 43289, 43499, 43659, 43999, 44238, 44799, 44899, 44979, 45499, 45999, 46999, 47379, 47399, 47579, 47999, 48999, 49329, 49659, 49999, 50549, 50949, 51999, 53899, 54699, 55559, 55899, 58578, 58579, 58679, 58999, 59897, 59898, 59899, 60659, 60699, 64999, 66999, 67299, 67399, 67599, 67999, 68399, 68899, 69399, 69799, 69949, 69979, 76496, 76497, 76498, 76499, 76999, 77299, 77399, 77499, 77799, 78099, 78199, 78299, 78399, 78499, 78599, 78699, 78799, 78999, 79999, 86486, 86999, 88099, 88199, 88299, 88399, 88749, 89240, 89398, 90399, 90749, 90899, 90999, 91299, 92499, 92700, 93799, 94799, 95199, 95999, 96379, 96549, 96999, 97039, 97139, 97799, 99199, 99429, 99499

## Dental Services

Dental claims will continue to be processed by the Division and will not migrate to MMIS on July 1, 2012. Community health centers and hospitals will be required to submit dental claims to the Division in the 5010 837D format only beginning May 1, 2012. Dental services (D codes) should not be billed to MMIS via HSN 837I or 837P claims.

The following dental CPT codes should not be submitted on an HSN 837I or 837P claim or they will be denied at the line level.

> 41820, 41874, 40840, 40842, 40843, 40844, 40845, 11440, 11441, 11442, 11443, 11444, 11446, 40806, 40819, 41010, 41115, 41520, 41525

These CPT codes have a corresponding CDT code that providers should submit to the HSN via the 837D claim format.

## Recurring Claims

Outpatient claims with statement from / through dates greater than one day cannot be submitted to MMIS. Separate claims must be submitted for each service date. Span dates are only allowed for outpatient claims where Medicare is in a claim's Coordination of Benefits (COB) segment.

Claim must be coded with Medicare payment amounts or adjudication information in order for processing of span dates to occur.

Providers have indicated that a unique patient account number (also known as TCN) cannot be provided in Loop 2300; CLM01 if separate claims must be submitted for patients with multiple outpatient service dates in a month. In these cases, unique patient account numbers do not need to be submitted. Providers should note that, for replacement claims, HSN remits will report the patient account number of the replacement claim and, if the previous claim was paid, the payment retraction will be reported via the patient account number coded on the previous claim.

Example of the above scenario would be:

Claim A is submitted with a patient account number of 123 and is subsequently paid $10. Provider submits a replacement claim (Claim B) with a patient account number of 456. HSN remit would report claim A with patient account number of 123 and a $10 payment retraction. If Claim B passed adjudication, it would be reported on the remit with patient account number of 456 and payment amount.

**Vision Benefit Plan**

Individuals enrolled in Commonwealth Care Bridge are eligible for dental and vision services only from the HSN. Providers should only bill vision services through MMIS as the Division will continue to process dental claims via the 837D format. Providers may only submit claims for vision services rendered to these members in accordance with the following benefit plan -

EVALUATION AND MANAGEMENT (E/M) SERVICES – OPTOMETRISTS ONLY

       Office or Other Outpatient E/M Visits: New Patient

    99201
    99202
    99203
    99204
    99205

       Office or Other Outpatient E/M Visits: Established Patient

    99211
    99212
    99213
    99214
    99215

OPHTHALMOLOGICAL OR OTHER SERVICES PROVIDED DURING AN E/M VISIT - OPTOMETRISTS ONLY

New or Established Patient

67820  Correction of trichiasis; epilation, by forceps only
92002   Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004  comprehensive, new patient, one or more visits
92012  Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014  comprehensive, established patient, one or more visits
92015   Determination of refractive state

Supplementary Testing

92065  Orthoptic and/or pleoptic training, with continuing medical direction and evaluation (PA)
92081  Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082  intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semi quantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083  extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30º, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100  Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure) (SP)
92132  Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral;
92133  Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
92134 Retina

Supplementary Testing – LEVEL II AND LEVEL III OPTOMETRISTS ONLY

76512   Ophthalmic ultrasound, diagnostic; contact B-scan (with or without simultaneous A-scan)
76513   anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
76514   corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
92020   Gonioscopy (separate procedure) (SP)
92120   Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method
92130  Tonography with water provocation

92140   Provocative tests for glaucoma, with interpretation and report, without tonography
92225   Ophthalmoscopy, extended with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial
92226  subsequent
92227   Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228   Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
92250   Fundus photography with interpretation and report (PA) (Both eyes equal one unit.)
92260   Ophthalmodynamometry
92275   Electroretinography with interpretation and report
92285   External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)
92541   Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542   Positional nystagmus test, minimum of four positions, with recording
92544   Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording

Contact Lenses – OPTICIANS AND OPTOMETRISTS ONLY

V2500  Contact lens, PMMA, spherical, per lens
V2501  Contact lens, PMMA, toric or prism ballast, per lens
V2503  Contact lens, PMMA, color vision deficiency, per lens (PA)
V2510  Contact lens, gas permeable, spherical, per lens
V2511  Contact lens, gas permeable, toric, prism ballast, per lens (PA)
V2512  Contact lens, gas permeable, bifocal, per lens (PA)
V2520  Contact lens, hydrophilic, spherical, per lens
V2521  Contact lens, hydrophilic, spherical, per lens
V2522  Contact lens, hydrophilic, bifocal, per lens (PA)

Contact Lenses Professional Services – OPTICIANS AND OPTOMETRISTS ONLY

92310   Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia (IC)
92326   Replacement of contact lens

Fitting of Spectacles – ACUTE HOSPITALS, COMMUNITY HEALTH CENTERS, OPHTHALMOLOGISTS, OPTICIANS, AND OPTOMETRISTS ONLY

92340   Fitting of spectacles, except for aphakia; monofocal (use for dispensing entire new initial eyeglasses, or entire new replacement eyeglasses, frame with lenses)

92341 bifocal (use for dispensing entire new initial eyeglasses, or entire new replacement eyeglasses, frame with lenses)

92342 multifocal, other than bifocal (use for dispensing entire new initial eyeglasses, or entire new replacement eyeglasses, frame with lenses)

Repairs and Replacement Parts – ACUTE HOSPITALS, COMMUNITY HEALTH CENTERS, OPHTHALMOLOGISTS, OPTICIANS, AND OPTOMETRISTS ONLY

92340-RB     Fitting of spectacles, except for aphakia; monofocal – Replacement and repair (use for dispensing replacement single vision lens, glass or plastic, including cataract lenses, per lens)

92341-RB     bifocal – Replacement and repair (use for dispensing replacement bifocal lens, glass or plastic, including cataract lenses, per lens)

92342-RB     multifocal, other than bifocal – Replacement and repair (use for dispensing replacement multifocal lens, other than bifocal, glass or plastic, including cataract lenses, per lens)

92370 Repair and refitting spectacles; except for aphakia (use for dispensing a replacement frame only, or any replacement frame components such as hinges or temples)

Miscellaneous – OCULARISTS, OPHTHALMOLOGISTS, OPTICIANS, AND OPTOMETRISTS

99173 Screening test of visual acuity, quantitative, bilateral (use for titmus vision test)

Miscellaneous – OPHTHALMOLOGISTS, OPTICIANS, AND OPTOMETRISTS ONLY

V2600 Hand-held low-vision aids and other nonspectacle-mounted aids (PA) (IC)

V2610 Single-lens spectacle-mounted low-vision aids (PA) (IC)

V2615 Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes, and compound microscopic lens system (PA) (IC)

Miscellaneous – OCULARISTS ONLY

V2623 Prosthetic eye, plastic, custom (IC)

V2624 Polishing/resurfacing of ocular prosthesis (IC)

V2625 Enlargement of ocular prosthesis (IC)

V2626 Reduction of ocular prosthesis (IC)

V2627 Scleral cover shell (IC)

V2628 Fabrication and fitting of ocular conformer (IC)

**Family Planning Services**

The Health Safety Net Office will pay for a medical visit for the purpose of family planning (family planning counseling services are considered part of the medical visit), prescribed drugs, family planning supplies and laboratory tests. The Office will not pay for a medical visit for the sole purpose of replenishing a patient's supply of contraceptives. In that case, the Office will pay only for the cost of the contraceptive supplies. Family planning services are approved via submission of a Confidential (CA) application for individuals less than 19 years of age. Submitted claims must be coded with the application ID as well as the MMIS ID assigned the via referred eligibility process.

FAMILY PLANNING CODES

Service Codes and Descriptions: Visits

New Patient

99201   Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
 - a problem-focused history;
 - a problem-focused examination; and
 - straightforward medical decision making

99202   Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
 - an expanded problem focused history;
 - an expanded problem focused examination;
 - straightforward medical decision making

99203   Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
 - a detailed history;
 - a detailed examination; and
 - medical decision making of low complexity

99205   Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
 - a comprehensive history;
 - a comprehensive examination; and
 - medical decision making of high complexity

Established Patient

99211   Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician (minimal service)

99212   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:  an expanded problem-focused history; an expanded problem-focused examination; medical decision making of low complexity (limited service)

99215   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity (comprehensive service)

Preventive Medicine, New Patient

99384   Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk  factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)

99385   Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years

Preventive Medicine, Established Patient

99394   Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)

99395   Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering  of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years

Preventive Medicine, Individual Counseling

99402   Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes (HIV pre- and post-test counseling only; two visits per day; maximum eight visits per year)

Service Codes and Descriptions: Contraceptive Supplies and Drugs

A4261  Cervical cap for contraceptive use (I.C.)

A4266  Diaphragm for contraceptive use (includes applicator and cream or jelly)

A4267  Contraceptive supply, condom, male, each

A4268  Contraceptive supply, condom, female, each

A4269 Contraceptive supply, spermicide (e.g., foam, gel), each (per package/tube)

J1055   Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (Use for Depo-Provera.) (I.C.)

J1056  Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (Use for Lunelle monthly contraceptive.) (I.C.)

J7303   Contraceptive supply, hormone-containing vaginal ring, each

J7304   Contraceptive supply, hormone-containing patch, each

J7307   Etonogestrel (contraceptive) implant system, including implants and supplies (must be billed with either 11975 or 11977)

S4989   Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies (I.C.)

S4993  Contraceptive pills for birth control

90649   Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), three-dose schedule, for intramuscular use (I.C.)

Service Codes and Descriptions: Medical and Surgery Procedures

11975   Insertion, implantable contraceptive capsules (must be billed with J7307)

11976   Removal, implantable contraceptive capsules (S.P.)

11977   Removal with reinsertion, implantable contraceptive capsules (must be billed with J7307)

19100   Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)

49080   Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial

56420   Incision and drainage of Bartholin's gland abscess

56501  Destruction of lesion(s), vulva; simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)

56605  Biopsy of vulva or perineum (separate procedure); one lesion

57061  Destruction of vaginal lesion(s); simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)

57100  Biopsy of vaginal mucosa; simple (separate procedure)

57420  Colposcopy of the entire vagina, with cervix if present

57421  with biopsy (ies)

57452  Colposcopy of the cervix including upper/adjacent vagina

57454  with biopsy(ies) of the cervix and endocervical curettage

57455  with biopsy(ies) of the cervix

57456  with endocervical curettage

57460  with loop electrode biopsy(ies) of the cervix

57461  with loop electrode conization of the cervix

57500  Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)

57505  Endocervical curettage (not done as part of a dilation and curettage)

57510  Cautery of cervix; electro or thermal

57511  cryocautery, initial or repeat

57513  laser ablation

57520  Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser

57522  loop electrode excision

58100  Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)

58340   Catherization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography

Service Codes and Descriptions: Laboratory Services

ORGAN OR DISEASE-ORIENTED PANELS

80055   Obstetric panel (This panel must include the following: blood count, complete (CBC), automated, and automated differential WBC count (85025 or 85027 and 85004) or blood count, complete (CBC), automated (85027), and appropriate manual differential WBC count (85007 or 85009); hepatitis B surface antigen (HBsAg) (87340); antibody, rubella (86762); syphilis test, non-treponemal antibody, qualitative (e.g., VDRL, RPR, ART) (86592), antibody screen, RBC, each serum technique (86850); blood typing, ABO (86900); and blood typing, Rh (D) (86901).)

80061   Lipid panel (This panel must include the following: cholesterol, serum, total (82465); lipoprotein,direct measurement, high density cholesterol (HDL cholesterol) (83718); and triglycerides (84478).)

80074   Acute hepatitis panel (This panel must include the following: hepatitis A antibody (HAAb); IgM antibody (86709); hepatitis B core antibody (HbcAb), IgM antibody (86705); hepatitis B surface antigen (HbsAg) (87340); and hepatitis C antibody (86803).)

80076   Hepatic function panel (This panel must include the following: albumin (82040); bilirubin, total (82247); bilirubin, direct (82248); phosphatase, alkaline (84075); protein, total (84155); transferase, alanine amino (ALT) (SGPT) (84460); and transferase, aspartate amino (AST) (SGOT) (84450).)

URINALYSIS

81000   Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated, with microscopy

81001   automated, with microscopy

81002   nonautomated, without microscopy

81003   automated, without microscopy

81005   Urinalysis; qualitative or semiquantitative, except immunoassays

81007   bacteriuria screen, except by culture or dipstick

81025   Urine pregnancy test, by visual color comparison methods

81099   Unlisted urinalysis procedure

CHEMISTRY

82040   Albumin; serum

82247   Bilirubin; total

82248   direct

82270   Blood, occult; by peroxidase activity (e.g., guaiac), qualitative; feces, 1-3 simultaneous determinations

82273   other sources

82310   Calcium; total

82465   Cholesterol, serum or whole blood, total

82540   Creatine

82550   Creatine kinase (CK), (CPK); total

82565   Creatinine; blood

82570   other source

82607   Cyanocobalamin (vitamin B-12)

82627   Dehydroepiandrosterone-sulfate (DHEA-S)

82670   Estradiol

82671   Estrogens; fractionated

82672   total

82677   Estriol

82679   Estrone

82746   Folic acid; serum

82947   Glucose; quantitative, blood (except reagent strip)

82950   post-glucose dose (includes glucose)

82951   tolerance test (GTT), three specimens (includes glucose)

82955   Glucose-6-phosphate dehydrogenase (G6PD); quantitative

82960   screen

83001   Gonadotropin; follicle-stimulating hormone (FSH)

83002   luteinizing hormone (LH)

83003   Growth hormone, human (HGH) (somatotropin)

83036   Hemoglobin; glycated

83491   Hydroxycorticosteroids, 17- (17-OHCS)

83540   Iron

83550   Iron-binding capacity

83586   Ketosteroids, 17- (17-KS); total

83593   fractionation

83615   Lactate dehydrogenase (LD), (LDH)

83625   isoenzymes, separation and quantitation

83718   Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)

84060   Phosphatase, acid; total

84066   prostatic

84075   Phosphatase, alkaline

84078   heat stable (total not included)

84080   isoenzymes

84132   Potassium; serum

84144   Progesterone

84146   Prolactin

84155   Protein, total, except by refractometry; serum

84156   urine

84157   other source (e.g., synovial fluid, cerebrospinal fluid)

84160   Protein, total, by refractometry, any source

84163   Pregnancy-associated plasma Protein-A (PAPP-A)

84165   Protein; electrophoretic fractionation and quantitation, serum

84166   electrophoretic fractionation and quantitation, other fluids with concentration (e.g., urine, CSF)

84295   Sodium; serum

84300   urine

84402   Testosterone; free

84403   total

84436   Thyroxine; total

84437   requiring elution (e.g., neonatal)

84439   free

84443   Thyroid-stimulating hormone (TSH)

84450   Transferase; aspartate amino (AST) (SGOT)

84460   alanine amino (ALT) (SGPT)

84478   Triglycerides

84479   Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)

84480   Triiodothyronine T3; total (TT-3)

84520   Urea nitrogen; quantitative

84550   Uric acid; blood

84590   Vitamin A

84702   Gonadotropin, chorionic (hCG); quantitative

84703   qualitative

HEMATOLOGY AND COAGULATION

85007   Blood count; blood smear, microscopic examination with manual differential WBC count

85008   blood smear, microscopic examination without manual differential WBC count

85009   manual differential WBC count, buffy coat

85013   spun microhematocrit

85014   hematocrit (Hct)

85018   hemoglobin (Hgb)

85025   complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count

85027   complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)

85041   red blood cell (RBC), automated

85610   Prothrombin time

85651   Sedimentation rate, erythrocyte; nonautomated

85652   automated

85660   Sickling of RBC, reduction

IMMUNOLOGY

86038   Antinuclear antibodies (ANA)

86171   Complement fixation tests, each antigen

86235   Extractable nuclear antigen, antibody to, any method (e.g., nRNP, SS-A, SS-B, Sm, RNP,  Sc170, J01), each antibody

86280   Hemagglutination inhibition test (HAI)

86308   Heterophile antibodies; screening

86309   titer

86310   titers after absorption with beef cells and guinea pig kidney

86317   Immunoassay for infectious agent antibody, quantitative, not otherwise specified

86318  Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (e.g., reagent strip)

86592   Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)

86593   quantitative

86628   Antibody; Candida

86631  86631 Chlamydia

86632   Chlamydia, IgM

86687   HTLV-I

86688   HTLV-II

86689   HTLV or HIV antibody, confirmatory test (e.g., Western Blot)

86692   hepatitis, delta agent

86694   herpes simplex, non-specific type test

86695   herpes simplex, type 1

86696   herpes simplex, type 2

86701   HIV-1

86702   HIV-2

86703   HIV-1 and HIV-2, single assay

86704   Hepatitis B core antibody (HBcAb); total

86705   IgM antibody

86706   Hepatitis B surface antibody (HBsAb)

86707   Hepatitis Be antibody (HBeAb)

86708   Hepatitis A antibody (HAAb); total

86709   IgM antibody

86762   Antibody; rubella

86781   Treponema pallidum, confirmatory test (e.g., FTA-abs)

86803   Hepatitis C antibody

86804   confirmatory test (e.g., immunoblot)

TRANSFUSION MEDICINE

86850   Antibody screen, RBC, each serum technique

86900   Blood typing; ABO

86901   Rh (D) (I.C.)

86906   Rh phenotyping, complete

MICROBIOLOGY

87070   Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates

87075   any source; except blood, anaerobic with isolation and presumptive identification of isolates

87081   Culture, presumptive, pathogenic organisms, screening only

87086   Culture, bacterial; quantitative colony count, urine

87088   with isolation and presumptive identification of isolates, urine

87101   Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail

87102   other source (except blood)

87103   blood

87110   Culture, Chlamydia, any source

87140   Culture, typing; immunofluorescent method, each antiserum

87164   Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection

87177   Ova and parasites, direct smears, concentration and identification

87181   Susceptibility studies, antimicrobial agent; agar dilution method, per agent (e.g., antibiotic gradient strip)

87184   disk method, per plate (12 or fewer agents)

87186   microdilution or agar dilution (minimum inhibitory concentration (MIC) or breakpoint), each multiantimicrobial, per plate

87188   macrobroth dilution method, each agent

87205   Smear, primary source; with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types

87206   fluorescent and/or acid-fast stain for bacteria, fungi, parasites, viruses, or cell types

87207   special stain for inclusion bodies or parasites (e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses)

87210   wet mount for infectious agents (e.g., saline, India ink, KOH preps)

87220   Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)

87252   Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect

87253   tissue culture, additional studies or definitive identification (e.g., hemabsorption, neutralization, immunofluoresence stain), each isolate

87270   Infectious agent antigen detection by immunofluorescent technique; chlamydia trachomatis

87273   herpes simplex virus type 2

87274   herpes simplex virus type 1

87285   Treponema pallidum

87320   Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Chlamydia trachomatis

87340   hepatitis B surface antigen (HBsAg)

87350   hepatitis Be antigen (HBeAg)

87380   hepatitis, delta agent

87390   HIV-1

87391   HIV-2

87480   Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique

87481   Candida species, amplified probe technique

87482   Candida species, quantification

87490   Chlamydia trachomatis, direct probe technique

87491   Chlamydia trachomatis, amplified probe technique

87492   Chlamydia trachomatis, quantification

87510   Gardnerella vaginalis, direct probe technique

87511   Gardnerella vaginalis, amplified probe technique

87512   Gardnerella vaginalis, quantification

87515   hepatitis B virus, direct probe technique

87516   hepatitis B virus, amplified probe technique

87517   hepatitis B virus, quantification

87520   hepatitis C, direct probe technique

87521   hepatitis C, amplified probe technique

87522   hepatitis C, quantification

87528   herpes simplex virus, direct probe technique

87529   herpes simplex virus, amplified probe technique

87530   herpes simplex virus, quantification

87534   HIV-1, direct probe technique

87535   HIV-1, amplified probe technique

87536   HIV-1, quantification

87537   HIV-2, direct probe technique

87538   HIV-2, amplified probe technique

87539   HIV-2, quantification

87590   Neisseria gonorrhoeae, direct probe technique

87591   Neisseria gonorrhoeae, amplified probe technique

87592   Neisseria gonorrhoeae, quantification

87620   papillomavirus, human, direct probe technique

87621   papillomavirus, human, amplified probe technique

87622   papillomavirus, human, quantification

87810   Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis

87850   Neisseria gonorrhoeae

ANATOMIC PATHOLOGY

 88104  Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation

88106   filter method only with interpretation

88107   smears and filter preparation with interpretation

88108   Cytopathology, concentration technique, smears and interpretation (e.g., Saccomanno technique)

88112   Cytopathology, selective cellular enhancement technique with interpretation (e.g., liquid based slide preparation method), except cervical or vaginal

88130   Sex chromatin identification; Barr bodies

88141   Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service.)

88142   Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision

88143   with manual screening and rescreening under physician supervision

88147   Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision

88148   screening by automated system with manual rescreening under physician supervision

88150   Cytopathology, slides, cervical or vaginal; manual screening under physician supervision

88152   with manual screening and computer-assisted rescreening under physician supervision

88153   with manual screening and rescreening under physician supervision

88154   with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

88160   Cytopathology, smears, any other source; screening and interpretation

88161   preparation, screening, and interpretation

88162   extended study involving over 5 slides and/or multiple stains (I.C.)

88164   Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision

88165   with manual screening and rescreening under physician supervision

88166   with manual screening and computer-assisted rescreening under physician supervision

86167   with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

88199   Unlisted cytopathology procedure (I.C.)

CYTOGENETIC STUDIES

88261   Chromosome analysis; count five cells, one karyotype, with banding

88262   count 15 to 20 cells, two karyotypes, with banding

88267   Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, one karyotype, with banding

88280   Chromosome analysis; additional karyotypes, each study

88285   additional cells counted, each study

SURGICAL PATHOLOGY

88300   Level I - surgical pathology, gross examination only

88302   Level II - surgical pathology, gross and microscopic examination

88304   Level III - surgical pathology, gross and microscopic examination

88305   Level IV - surgical pathology, gross and microscopic examination

88307   Level V - surgical pathology, gross and microscopic examination

88309   Level VI - surgical pathology, gross and microscopic examination

OTHER PROCEDURES

89050   Cell count, miscellaneous body fluids (e.g., cerebrospinal fluid, joint fluid), except blood

99213  Office or other outpatient visit for the evaluation and management of an established patient, that requires at least two of these three key components,"an expanded problem-focused history,"an expanded problem-focused examination,"medical decision-making of low complexity"

J2790  Injection, Rho (D) immune globulin, human, one-dose package (when required only; reimbursed at the actual wholesale cost of the serum; a copy of the purchase invoice must be submitted with the claim form) (I.C.)

S0190  Mifepristone, oral, 200 mg

S0191  Misoprostol, oral, 200 mcg

S0199  Medically induced abortion by oral ingestion of medication, including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by Hcg, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion), except drugs

59820  Treatment of missed abortion, completed surgically, first trimester (includes physician's charges and clinic services)

59840  Induced abortion, by dilation and curettage (first trimester) (includes physician's charges and clinic services with either intravenous sedation or general anesthesia; CPA-2 form required)

59840-TF    Induced abortion, by dilation and curettage (second trimester—12.1 through 13.9 weeks; includes physician's charges and clinic services with either intravenous sedation or general anesthesia; CPA-2 form required)

59840-TG    Induced abortion by dilation and curettage (second trimester—14.0 through 18.9 weeks; includes physician's charges and clinic services with either intravenous sedation or general anesthesia and insertion of cervical dilator, e.g., laminaria; CPA-2 form required)

59841  Induced abortion, by dilation and evacuation (first trimester) (includes physician's charges and clinic services; CPA-2 form required)

59841-TF    Induced abortion, by dilation and evacuation (second trimester—12.1 through 13.9 weeks; includes physician's charges and clinic services with either intravenous sedation or general anesthesia; CPA-2 form required)

59841-TG    Induced abortion, by dilation and evacuation (second trimester—14.0 through 18.9 weeks; includes physician's charges and clinic services with either intravenous sedation or general anesthesia, and insertion of cervical dilator, e.g., laminaria; CPA-2 form required)

76805  Ultrasound, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)

76815  limited (fetal size, heartbeat, placental location, fetal position, or emergency in the delivery room)

**Segment Detail**

| Loop | Segment | Element Name | Companion Information |
|---|---|---|---|
| | ISA06 | Interchange Sender ID | **Trading Partner / Provider ID assigned by MassHealth** |
| | ISA08 | Interchange Receiver ID | **HSN3644** |
| | ISA14 | Acknowledgement Requested | **0 = No interchange acknowledgement requested (TA1)** <br> **1 = Interchange acknowledgement requested (TA1)** |
| | GS03 | Application Receiver's Code | **HSN3644** |
| 1000B | NM109 | Receiver Identification Code | **HSN3644** |
| 2000B | SBR01 | Payer Responsibility Sequence Number Code | **P = HSN is Primary** <br><br> **S = HSN is Secondary** <br><br> **T = HSN is Payer of Last Resort when more than two prior payers are present on claim** <br><br> **Values A – H will be treated the same as T.** |
| 2000B | SBR04 | Name | **Allowable HSN Types:** <br><br> **Prime = HSN is the sole payer (SBR01 = P)** <br><br> **Second = HSN is both the secondary and last payer (SBR01 = S or T)** <br><br> **Partial = HSN will pay for a portion of the claim after certain subscriber responsibility (SBR01 = P, S or T)** <br> **BD = Subscriber is uninsured and has no HSN Eligibility and the claim is for ER Bad Debt (SBR01 = P)** <br> **CA = Subscriber may have other coverage but requires anonymity (SBR01 = P, S or T); requires Application number reporting in Loop 2300 REF02 where REF01 = G1** <br><br> **MH = Subscriber has no HSN Eligibility and is eligible for financial aid with medical expenses (SBR01 = P, S or T); requires Application number reporting in Loop 2300 REF02 where** |

| | | | REF01 = G1 |
|---|---|---|---|
| 2000B | SBR09 | Subscriber Information Claim Filing Indicator Code | ZZ |
| 2010BA | NM102 | Entity Type Qualifier | Report 1 for all claims other than bad debt where an MMIS ID is present. For bad debt claims only AND when an MMIS ID is not present, a value of 2 should be reported. |
| 2010BA | NM108 | Identification Code Qualifier | MI |
| 2010BA | NM109 | Subscriber Identification Code | Report the 12-character MassHealth member's recipient identification number (RID) when Subscriber has HSN Eligibility; else, leave field blank. Do not report a dummy number (i.e, 000000000001) |
| 2010BA | REF01 | Reference Identification Qualifier | Subscriber Secondary Identification segment should be omitted when SSN is unknown |
| 2010BA | REF02 | Subscriber Secondary ID Code | Report the Subscriber's SSN Do not report a dummy number (i.e., 000000001) |
| 2010BB | NM108 | Identification Code Qualifier | PI |
| 2010BB | NM109 | Payer Identification Code | 995 |
| 2300 | CLM01 | Claim Submitter's Identifier | Report patient account number (also known as TCN). Must be a unique identifier without further enumeration on resubmissions and/or voids. |
| 2300 | CLM05-1 | Facility Code Value | 11 = Inpatient Hospital Facility<br>13 = Outpatient Hospital Facility<br>No other facility values accepted for HSN claims |
| 2300 | CLM05-3 | Claim Frequency Type Code | 1 = Admit thru Discharge Claim<br>7 = Replacement Claim<br>8 = Void Claim<br><br>No other frequency values accepted for HSN claims |
| 2300 | CL101 | Admission Type Code | Report only valid, meaningful Admit Type Codes in accordance with HSN code list. 9 is allowed when Medicare is primary to HSN |
| 2300 | CL102 | Admission Source Code | Report only valid Admit Source Codes in accordance with HSN code list. Adhere to |

| 2300 | | | Newborn Coding when appropriate. |
|------|------|------|------|
| 2300 | CL103 | Patient Status Code | Report only valid, meaningful Patient Status Codes in accordance with HSN code list. |
| 2300 | AMT01 | Amount Qualifier Code | F3 |
| 2300 | AMT02 | Monetary Amount | Report any balances calculated to be Patient (Subscriber) amount due when SBR04 = Partial |
| 2300 | REF01 | Reference Identification Qualifier | Submission of this segment with REF01 = G1 (Prior Authorization Number) is required when SBR04 = CA or MH. |
| 2300 | REF02 | Reference Identification Code | Report HSN CA/MH Application number |
| 2300 | HI01-1 | Code List Qualifier Code for Occurrence Span Information | BI; segment required to report Administrative Days |
| 2300 | HI01-2 | Industry Code | Use for Administrative Day reporting: 75 = indicates HSN is to consider SNF Level of Care days at an Acute Facility

M4 = indicates HSN is to consider Residential Level of Care days at an Acute Facility |
| 2300 | HI01-3 | Date Time Period Format Qualifier | RD8 |
| 2300 | HI01-4 | Date Time Period | CCYYMMDD-CCYYMMDD format |
| 2300 | HI01-1 | Code List Qualifier Code for Occurrence Information | BH; segment required to report BD Write off date OR split eligibility date OR First Outlier Day |
| 2300 | HI01-2 | Industry Code | Use for BD reporting:

A2 = HSN is Primary and no other payers for BD

Use for Split Eligibility

A3 = When HSN is Primary for part of the multiple day service

B3 = When HSN is Secondary and Payer of Last Resort

C3 = When HSN is Payer of Last Resort with two or more payers

Use for Outlier Days

47 = First day for Outlier Billing, typically the 21st day when HSN is Secondary to MassHealth. |

| 2300 | HI01-3 | Date Time Period Format Qualifier | D8 |
|---|---|---|---|
| 2300 | HI01-4 | Date Time Period | CCYYMMDD |
| 2300 | HI01-1 | Code List Qualifier Code for Value Information | BE; segment required to report BD Write off amount |
| 2300 | HI01-2 | Industry Code | Use for BD reporting:<br><br>A3 = When HSN is Primary for BD Claim |
| 2310E | NM109 | Identification Code | Do not send elements NM108 or NM109. |
| 2310E | N301 | Address Information | Report street address of service facility; utilize N302 if applicable |
| 2310E | N401 | City Name | Report city of service facility |
| 2310E | N402 | State or Province Name | Report state of service facility |
| 2310E | N403 | Postal Code | Report zip code of service facility |
| 2310E | REF01 | Reference Identification Qualifier | LU |
| 2310E | REF02 | Reference Identification | Report HSN Site Org ID (as currently assigned by DHCFP) |
| 2400 | SV201 | Product / Service ID | Report only valid revenue codes<br>Inpatient revenue codes cannot be reported on outpatient claims. |
| 2400 | SV207 | Monetary Amount | Report total noncovered amount here |