June 25, 2012

837 Health Care Claim: Professional

MMIS Claims Migration Billing Guide

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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 specifies use of specific segments and specific 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:* Hospitals may submit professional charges to the HSN only when services are rendered by a hospital employed physician. With migration to MMIS, professional charges must be submitted on the 837P format (Version 5010) in accordance with MassHealth billing rules. 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 2310C; 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: Billing deadlines will be waived for hospital professional (837P) claims submitted from July through December 2012 with dates of service of October 1, 2011 or later. 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.

Claim level (Loop 2300) K3 Segment

Community health center providers will report data regarding partial claims in this segment. The K3 segment should not be reported in the same location as the CN1 segment. The CN1 segment is located in Loop 2300, position 1600. The K3 segment is located in Loop 2300, position 1850, after all of the REF segments but before all of the HI segments.

Claims will fail 5010 compliance edits if segments are coded out of sequence. The K3 segment must be coded with a prefix of "MAHSN" that must be followed by a terms discount value of "20" or "100." Term discount values of "20" or "100" must be submitted in position 6 of K301.

K301 (Fixed Format Information) should be coded in the following format:

Terms Discount:

20 or 100 for Partial eligibility (where SBR04 = Partial)

20 = Partial amount still due and percentage of payment needs to be calculated.
100 = Partial amount has been met and percentage of payment does not need to be calculated.

If the K3 segment is not provided or provided with a value other than "20" or "100," a percentage of payment will be calculated. Although reporting of the partial start date via the K3 will no longer be required, providers will remain responsible for tracking a patient's deductible in accordance with HSN regulations.

Examples:

1) HSN Partial claim where deductible has not been met (K3*MAHSN20)
2) HSN Partial claim where deductible has been met (K3*MAHSN100)

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

837P 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.

837P claims where no other payer is present (SBR01 = P) and where claim type (SBR04) is Partial or Bad Debt: HSNEAD = Total Claim Charge Amount reported in Loop 2300, CLM02 *minus* Patient Amount Paid reported in Loop 2300, AMT02 (where AMT01 = F5)*.

Payment for Claims where HSN is not Primary

837P 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 = F5)* *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

* 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.*

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.

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.

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)** **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** **S = HSN is Secondary** **T = HSN is Payer of Last Resort when more than two prior payers are present on claim** **Values A – H will be treated the same as T.**
2000B	**SBR04**	**Name**	**Allowable HSN Types:** **Prime = HSN is the sole payer (SBR01 = P)** **Second = HSN is both the secondary and last payer (SBR01 = S or T)** **Partial = HSN will pay for a portion of the claim after certain subscriber responsibility (SBR01 = P, S or T)** **BD = Subscriber is uninsured and has no HSN Eligibility and the claim is for ER Bad Debt (SBR01 = P)** **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**

			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**	**HOSPITAL** **21 = Inpatient Hospital** **22 = Outpatient Hospital** **23 = Emergency Room – Hospital** **HEALTH CENTER PLACE OF SERVICE CODES** **01 = Pharmacy** **03 = School** **11 = Office** **20 = Urgent Care Facility**

			21 = Inpatient Hospital **22 = Outpatient Hospital** **23 = Emergency Room – Hospital** **24 = Ambulatory Surgical Center** **53 = Community Mental Health Center** **No other facility values accepted for HSN claims**
2300	**CLM05-3**	**Claim Frequency Type Code**	**1 = Admit thru Discharge Claim** **7 = Replacement Claim** **8 = Void Claim** **No other frequency values accepted for HSN claims**
2300	**K301**	**Terms Discount**	**Report "20" or "100" for Partial eligibility (where SBR04 = Partial).** **Must be coded with prefix of "MAHSN" followed by terms discount value of "20" or "100"** **20 = Partial amount still due and percentage of payment needs to be calculated.** **100 = Partial amount has been met and percentage of payment does not need to be calculated.**
2300	**AMT01**	**Amount Qualifier Code**	**F5**
2300	**AMT02**	**Monetary Amount**	**Patient Paid Amount**
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**
2310C	**NM109**	**Identification Code**	**Do not send elements NM108 or NM109**
2310C	**N301**	**Address Information**	**Report street address of service facility; utilize N302 if applicable**
2310C	**N401**	**City Name**	**Report city of service facility**
2310C	**N402**	**State or Province Name**	**Report state of service facility**
2310C	**N403**	**Postal Code**	**Report zip code of service facility**
2310C	**REF01**	**Reference Identification Qualifier**	**LU**

2310C	**REF02**	**Reference Identification**	**Report HSN Site Org ID (as currently assigned by DHCFP)**