

# Table of Contents

## Billing & Reimbursement for Ancillary Services

|  |            |
|--|------------|
| <b>Overview</b> .....                            | <b>8.1</b> |
| <b>Ambulance services</b> .....                  | <b>8.1</b> |
| Preapproval/Precertification requirements .....  | 8.1        |
| Billing information .....                        | 8.1        |
| Electronic billing (837P).....                   | 8.1        |
| Paper billing.....                               | 8.1        |
| <b>Ambulatory surgical center services</b> ..... | <b>8.2</b> |
| Preapproval/Precertification requirements .....  | 8.2        |
| Billing information .....                        | 8.2        |
| Electronic billing (837I).....                   | 8.2        |
| Paper billing (UB-04) .....                      | 8.2        |
| Sequencing.....                                  | 8.3        |
| Payment for multiple surgical procedures .....   | 8.3        |
| Revenue codes .....                              | 8.3        |
| Charges for procedures .....                     | 8.3        |
| Incidental procedures.....                       | 8.3        |
| <b>Birth centers</b> .....                       | <b>8.4</b> |
| Preapproval/Precertification requirements .....  | 8.4        |
| Billing information .....                        | 8.4        |
| Electronic billing (837I).....                   | 8.4        |
| Paper billing (UB-04) .....                      | 8.5        |
| <b>Dialysis centers</b> .....                    | <b>8.5</b> |
| Preapproval/Precertification requirements .....  | 8.5        |
| Billing information .....                        | 8.5        |
| Electronic billing (837I).....                   | 8.5        |
| Paper billing (UB-04) .....                      | 8.5        |
| Billing procedures.....                          | 8.6        |
| Notice of Medicare coverage.....                 | 8.6        |
| <b>Durable medical equipment</b> .....           | <b>8.7</b> |
| Preapproval/Precertification requirements .....  | 8.7        |
| Billing information .....                        | 8.7        |

# Table of Contents

## Billing & Reimbursement for Ancillary Services

|   |             |
|---|-------------|
| Electronic billing (837P).....                  | 8.7         |
| Paper billing.....                              | 8.8         |
| <b>Freestanding sleep study centers .....</b>   | <b>8.8</b>  |
| Preapproval/Precertification requirements ..... | 8.8         |
| Billing information .....                       | 8.8         |
| Electronic billing (837I).....                  | 8.8         |
| Paper billing (UB-04) .....                     | 8.8         |
| Fee schedule billing and reimbursement.....     | 8.9         |
| <b>Home health .....</b>                        | <b>8.9</b>  |
| Preapproval/Precertification requirements ..... | 8.9         |
| Billing information .....                       | 8.9         |
| Electronic billing (837I).....                  | 8.9         |
| Paper billing (UB-04) .....                     | 8.9         |
| Mother’s Option <sup>®</sup> .....              | 8.10        |
| Billing information .....                       | 8.10        |
| Perinatal/Baby FootSteps <sup>®</sup> .....     | 8.11        |
| Billing information .....                       | 8.11        |
| Home infusion therapy.....                      | 8.12        |
| Billing information .....                       | 8.12        |
| Electronic billing (837P).....                  | 8.12        |
| Paper billing.....                              | 8.13        |
| Private-duty nursing.....                       | 8.13        |
| Billing information .....                       | 8.13        |
| Electronic billing.....                         | 8.13        |
| Paper billing.....                              | 8.13        |
| <b>Hospice.....</b>                             | <b>8.14</b> |
| Preapproval/Precertification requirements ..... | 8.14        |
| Billing information .....                       | 8.14        |
| Electronic billing (837I).....                  | 8.14        |
| Paper billing (UB-04) .....                     | 8.15        |
| <b>Independent laboratory .....</b>             | <b>8.15</b> |

# Table of Contents

## Billing & Reimbursement for Ancillary Services

|  |             |
|--|-------------|
| Preapproval/Precertification requirements .....                                | 8.15        |
| Billing information .....  | 8.15        |
| Electronic billing (837P).....   | 8.15        |
| Paper billing.....   | 8.15        |
| <b>Lithotripsy centers.....</b>  | <b>8.16</b> |
| Preapproval/Precertification requirements .....                                | 8.16        |
| Billing information .....  | 8.16        |
| Electronic billing (837I).....   | 8.16        |
| Paper billing (UB-04) .....  | 8.16        |
| <b>Skilled nursing facility.....</b>   | <b>8.16</b> |
| Preapproval/Precertification requirements .....                                | 8.16        |
| Billing information .....  | 8.17        |
| Electronic billing (837I).....   | 8.17        |
| Paper billing (UB-04) .....  | 8.17        |
| Managed care products .....  | 8.18        |
| Referrals for HMO Members in long-term care/custodial-care nursing homes ..... | 8.18        |
| Part B therapy services for Medicare Advantage Members .....                   | 8.19        |

# Billing & Reimbursement for Ancillary Services

## Overview

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The purpose of this section is to describe the specific billing requirements for services rendered by ancillary facility and ancillary professional providers and to supplement the *General Information* section.

## Ambulance services

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### Preapproval/Precertification requirements

- Preapproval/Precertification is required for all non-emergent ambulance transport, except for transport from one acute-care setting to another (billed with HH modifier). Please complete field locator 23 on the CMS-1500 form.
- Transfers from a medical facility to a mental health facility by ambulance must be Preapproved by Magellan Behavioral Health, Inc.

A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

### Billing information

AmeriHealth requires that contracting ambulance providers submit their claims on a CMS-1500 form. Please take special notice of the following billing requirements that may be unique to AmeriHealth claims:

- The National Provider Identifier (NPI) assigned to your organization must appear on every claim.
- Only those services specified in your Agreement will be reimbursed.

#### *Electronic billing (837P)*

##### **National Association of Insurance Commissioners (NAIC) codes**

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate payer ID list at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through Electronic Data Interchange (EDI), you will receive a Functional Acknowledgement (FA)/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing, as well as those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI support group at [215-241-2305](tel:215-241-2305).

For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

#### ***Paper billing***

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

# Billing & Reimbursement for Ancillary Services

## Ambulatory surgical center services

### Preapproval/Precertification requirements

Precertification/Preapproval is based on the HCPCS and CPT<sup>®</sup> codes for the planned procedure. If there is a change to the planned procedure, the HCPCS and CPT codes on the claim may be different from the code originally reported. Assuming the codes are reasonably related, this is not a barrier for payment. Significant discrepancies may be questioned prior to payment.

A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

### Billing information

AmeriHealth requires contracted ambulatory surgical center (ASC) claims to be submitted using the UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at [www.amerihealth.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- Preapproval/Precertification numbers, when applicable, should appear in field locator 63.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- The correct bill type, 83X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- A “no-pay” bill must also be sent to the fiscal intermediary for any AmeriHealth 65<sup>®</sup> Member.

### *Electronic billing (837I)*

#### **NAIC codes**

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate payer ID list at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

### *Paper billing (UB-04)*

If you must submit a claim on paper, you will need to bill on a UB-04 form.

# Billing & Reimbursement for Ancillary Services

## *Sequencing*

Claims with multiple surgical procedures are processed in the order they appear on the claim. Please be sure to bill the procedure with the highest allowable (primary) procedure first. AmeriHealth does not reorder the claim lines; however, some clearinghouses use software that changes the order, thus affecting the processing by AmeriHealth.

## *Payment for multiple surgical procedures*

When multiple surgical procedures are performed on the same date of service, the highest allowable (primary) procedure is paid at 100 percent of the fee schedule rate, and the remaining procedures are paid at 50 percent of the fee schedule rate.

## *Revenue codes*

ASCs should use the following revenue code for surgery claims: 0490. The same revenue code should be used for each procedure. When providers bill with different revenue codes, there is no additional reimbursement.

| <b>Example 1:</b> | <b>Rev code</b> | <b>CPT/HCPCS</b> | <b>Status</b>               | <b>Percent</b> |
|-------------------|-----------------|------------------|-----------------------------|----------------|
|                   | 0490            | 23410            | Highest allowable (primary) | 100%           |
|                   | 0490            | 36530            | Second highest allowable    | 50%            |
|                   | 0490            | 11402            | Second highest allowable    | 50%            |
| <b>Example 2:</b> | <b>Rev code</b> | <b>CPT/HCPCS</b> | <b>Status</b>               | <b>Percent</b> |
|                   | 0490            | 67105            | Highest allowable (primary) | 100%           |
|                   | 0490            | 67105            | No reimbursement            | –              |

## *Charges for procedures*

All billed procedures must have corresponding charges. AmeriHealth cannot accept procedures with a \$0.00 charge. If your system rolls up all charges to the first procedure, be sure to drop down a nominal amount (e.g., \$1.00) to the other procedures.

| <b>Example:</b> | <b>Rev Code</b> | <b>CPT/HCPCS</b> | <b>Charges</b> | <b>Status</b>               | <b>Percent</b> |
|-----------------|-----------------|------------------|----------------|-----------------------------|----------------|
|                 | 0490            | 36530            | \$1810.00      | Highest allowable (primary) | 100%           |
|                 | 0490            | 11402            | \$1.00         | Second highest allowable    | 50%            |

## *Incidental procedures*

When multiple procedures are billed, no additional payment is made for procedures that are considered incidental to the highest allowable (primary) procedure. The Member may not be balance-billed for incidental procedures (IP).

Payment for an IP is made when that procedure is the only one performed or when it is the highest allowable (primary) procedure for the episode of care. When multiple procedures are performed and all are incidental, only the IP that is the highest allowable (primary) procedure is reimbursed.

IPs are marked with an “IP” on the ASC Surgery Fee Schedule.

# Billing & Reimbursement for Ancillary Services

| Example: | Rev Code | CPT/HCPCS | Incidental | Status                      | Percent |
|----------|----------|-----------|------------|-----------------------------|---------|
|          | 0490     | 29877     | IP         | Highest Allowable (primary) | 100%    |
|          | 0490     | 29880     | IP         | Second highest allowable    | –       |
|          | 0490     | 11402     | –          | Second highest allowable    | 50%     |
|          | 0490     | 58120     | IP         | Second highest allowable    | –       |

*Note:* Updates are made periodically to the ASC Surgery Fee Schedule.

## Birthing centers

### Preapproval/Precertification requirements

A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

### Billing information

AmeriHealth requires all birthing center claims to be submitted using the UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at [www.amerihealth.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- A charge amount must appear in the total charge field for each line item. Lines with zero dollar charges will not be accepted. The amount billed must be greater than zero.
- The correct bill type, 84X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.

### *Electronic billing (837I)*

#### NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing as well as those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

# Billing & Reimbursement for Ancillary Services

## ***Paper billing (UB-04)***

If you must submit a claim on paper, you will need to bill on a UB-04 form.

## **Dialysis centers**

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### **Preapproval/Precertification requirements**

A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

### **Billing information**

AmeriHealth requires all dialysis center claims to be submitted using a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at [www.amerihealth.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- The correct bill type, 72X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- A charge amount must appear in the total charge field for each line item. Lines with zero dollar charges will not be accepted. The amount billed must be greater than zero.
- All bills must be submitted on a monthly basis.
- Referrals for HMO Members are not required.

### ***Electronic billing (837I)***

#### **NAIC codes**

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing, as well as those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

### ***Paper billing (UB-04)***

If you must submit a claim on paper, you will need to bill on a UB-04 form.



# Billing & Reimbursement for Ancillary Services

In order to ensure correct claim payment, please use the following revenue codes when billing for services rendered in accordance with your Agreement:

| Revenue code<br>(UB-04 field locator 42) | Description<br>(UB-04 field locator 43) |
|--|---|
| 0821                                     | Hemodialysis                            |
| 0825                                     | Hemodialysis with training              |
| 0829                                     | Home dialysis training and treatment    |
| 0831                                     | Peritoneal dialysis                     |
| 0835                                     | Peritoneal dialysis with training       |
| 0841                                     | CAPD dialysis                           |
| 0845                                     | CAPD dialysis with training             |
| 0851                                     | CCPD dialysis                           |
| 0855                                     | CCPD dialysis with training             |

## Billing procedures

The following requirements for submitting claims to AmeriHealth for renal dialysis services are based on Medicare's billing instructions (National Uniform Billing Committee/Health Care Financing Administration [HCFA]). In order for your claims to be accepted and processed by AmeriHealth, the billing requirements defined below must be used.

*Note:* Follow the coding guidelines in the current UB-04 and ICD-9-CM/CPT manuals when reporting all services.

**HCPCS/CPT codes:** HCPCS/CPT codes are required when reporting services in the following series of revenue codes:

|            |            |            |            |            |
|------------|------------|------------|------------|------------|
| <b>30X</b> | <b>31X</b> | <b>32X</b> | <b>73X</b> | <b>92X</b> |
| <b>82X</b> | <b>3X</b>  | <b>84X</b> | <b>85X</b> | <b>636</b> |

## Notice of Medicare coverage

Upon enrollment of any AmeriHealth Member, participating dialysis centers must submit to AmeriHealth a copy of the Medicare HCFA-2728 form that is sent to the Renal Networks. These forms are needed to facilitate our Member reconciliation efforts with those of the Centers for Medicare & Medicaid Services (CMS) and to ensure appropriate coordination of benefits. Please submit forms for AmeriHealth Members covered under all products referred to in this manual to:

AmeriHealth  
1901 Market Street  
29th floor  
Philadelphia, PA 19103-1480

Please refer to the *General Information* section of this manual for claims information.

# Billing & Reimbursement for Ancillary Services

## Durable medical equipment

### Preapproval/Precertification requirements

- Purchased durable medical equipment (DME): Preapproval/Precertification is required for purchased DME costing \$500 or more per line item (except diabetic supplies, unit dose medications for nebulizers, and ostomy supplies).
- Rental DME: Preapproval/Precertification is required for all DME rentals (with the exception of oxygen), regardless of price.
- Preapproval/Precertification is required for the repair and/or replacement of DME and prosthetic devices.

A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

*Note:* Member benefits should always be verified as some groups have Preapproval/Precertification requirements for services over \$100.

### Billing information

AmeriHealth requires that contracting DME providers submit their claims on a CMS-1500 form. A description of how to complete a CMS-1500 form can be found at [www.amerihealth.com/providers/claims\\_and\\_billing/claim\\_requirements.html](http://www.amerihealth.com/providers/claims_and_billing/claim_requirements.html).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim.
- The “from” and “to” dates of care must be provided.
- A Certificate of Medical Necessity is not required for billing but must be kept on file with the patient’s chart to be made available upon request.
- The claim form must show a written description for any miscellaneous billed service that has not been defined or priced.

*Note:* The above information is subject to state mandates.

### *Electronic billing (837P)*

#### **NAIC codes**

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI support group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

# Billing & Reimbursement for Ancillary Services

## *Paper billing*

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

## Freestanding sleep study centers

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### Preapproval/Precertification requirements

Preapproval/Precertification is required for HMO Members. A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

### Billing information

AmeriHealth requires sleep study center claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at [www.amerihealth.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf).

In order for a sleep study center to be eligible as an approved sleep study center for AmeriHealth's network, the center must be accredited by the Joint Commission or the American Association of Sleep Medicine.

Please take special note of the following guidelines:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The correct bill type, 89X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to your facility.
- Only those services specified in your Agreement will be reimbursed.

### *Electronic billing (837I)*

#### NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent monthly. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

### *Paper billing (UB-04)*

If you must submit a claim on paper, you will need to bill on a UB-04 form.

# Billing & Reimbursement for Ancillary Services

## *Fee schedule billing and reimbursement*

Fee schedules are the method of reimbursement for procedures performed in the sleep study center. Freestanding sleep study centers are reimbursed on a standard fee schedule. Physician services are separately billable.

## Home health

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### Preapproval/Precertification requirements

All home health services require timely Preapproval/Precertification. A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

### Billing information

AmeriHealth requires all home health claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately, whether you bill via EDI or on paper. A description of how to complete a UB-04 form can be found at [www.amerihealth.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported “statement from” and “statement through” dates.
- The revenue codes listed in this section should be used to bill home health services.
- The correct bill type, 33X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- Be sure that all the required form fields are completed.
- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).

### *Electronic billing (837I)*

#### NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI support group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

### *Paper billing (UB-04)*

If you must submit a claim on paper, you will need to bill on a UB-04 form.

# Billing & Reimbursement for Ancillary Services

| Covered Services |  |
|------------------|--|
| Revenue code     | Description  |
| 0421             | Physical therapy, visit charge   |
| 0431             | Occupational therapy, visit charge   |
| 0441             | Speech therapy, visit charge   |
| 0551             | Skilled nursing, visit charge  |
| 0561             | Medical social worker, visit charge  |
| 0571             | Home health aide (hourly rate)   |
| 0590             | Nutrition consultation, visit charge – benefit only for Managed Care benefit programs; not for CMM |

## Mother's Option<sup>®</sup>

### *Billing information*

AmeriHealth requires all Mother's Option claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately, whether you bill via EDI or on paper. A description of how to complete a UB-04 form can be found at [www.amerhealth.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.amerhealth.com/pdfs/providers/npi/ub04_form.pdf).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- Preapproval/Precertification is not required for the Mother's Option well-mom/baby home care visit, provided that the visit(s) complies with the Mother's Option guidelines.
- The claim should be billed with the mother as the patient, never the baby. If additional visits for the baby are needed, Preapproval/Precertification should be obtained and the service should be billed under your home health provider number.
- Timely Preapproval/Precertification is required for all phototherapy services. A separate authorization should be obtained for the skilled nursing visit and for the rental of the Wallaby<sup>®</sup> blanket.
- Phototherapy claims must always be billed with the baby as the patient.
- The revenue codes listed in this section should be used to bill Mother's Option services.
- The reported service dates must fall within the reported "statement from" and "statement through" dates.
- The correct bill type, 33X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- Be sure that all the required fields are filled in.
- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).
- For more information, please see the *Care Management and Coordination* section of this manual.

*Note:* Self-funded groups are not required to follow any state mandates, including the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA of 96). Be sure to verify that a baby has been added to a policy prior to billing phototherapy or standard home care services.

# Billing & Reimbursement for Ancillary Services

| Mother's Option <sup>®</sup> |   |
|------------------------------|---|
| Revenue code                 | Description                                 |
| 0551                         | Well-mom/baby, visit charge                 |
| 0291                         | Phototherapy (Wallaby rental), daily charge |

| Covered diagnoses |                               |
|-------------------|-------------------------------|
| Diagnosis code    | When reporting service        |
| V24.2, 650        | Well-mom/baby visit           |
| 774.6             | Phototherapy (Wallaby rental) |

## Perinatal/Baby FootSteps<sup>®</sup>

### Billing information

AmeriHealth requires all Perinatal/Baby FootSteps claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately, whether you bill via EDI or on paper. A description of how to complete a UB-04 form can be found at [www.amerhealth.com/pdfs/providers/mpi/ub04\\_form.pdf](http://www.amerhealth.com/pdfs/providers/mpi/ub04_form.pdf).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- All perinatal services require timely Preapproval/Precertification.
- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported “statement from” and “statement through” dates.
- The revenue codes listed in this section should be used to bill perinatal services.
- The correct bill type, 33X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- Be sure that all the required form fields are completed.
- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).

| Covered Services |                                      |
|------------------|--------------------------------------|
| Revenue code     | Description                          |
| 0551             | Skilled nursing, visit charge        |
| 0561             | Medical social worker, visit charge  |
| 0571             | Home health aide, hourly charge      |
| 0589             | Fetal non-stress test, visit charge  |
| 0590             | Nutrition consultation, visit charge |

# Billing & Reimbursement for Ancillary Services

## Home infusion therapy

### *Billing information*

AmeriHealth requires that contracting infusion therapy providers submit their claims on a CMS-1500 form. A description of how to complete a CMS-1500 form can be found at [www.amerihealth.com/providers/claims\\_and\\_billing/claim\\_requirements.html](http://www.amerihealth.com/providers/claims_and_billing/claim_requirements.html).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- All home infusion services require Preapproval/Precertification. For more information please visit [www.amerihealth.com/medpolicy](http://www.amerihealth.com/medpolicy).
- Claims must be submitted biweekly or monthly.
- The NPI assigned to your organization must appear on every claim.
- The start and end dates of care must be provided.
- Only those services specified in your Agreement will be reimbursed.
- When more than one antibiotic therapy is administered, it must be reported with the correct approval number assigned for each therapy.
- When reporting hydration therapy, only one rate shall be reimbursable on a per-day basis, regardless of volume used.
- The line maintenance services are reported only when a Member is not receiving active therapy.
- National Drug Code (NDC) numbers are used for determining the average wholesale price (AWP) of the drug component. The AWP is determined using First DataBank pricing. When billing for a drug used in conjunction with infusion therapy, you must use the NDC number of the dispensed drug and the number of units dispensed. Each NDC number must appear on a separate line of the claim form.

*Note:* A new edit to validate the NDC submitted on paper and electronic claims for claims submitted with an unlisted and nonspecific drug code became effective January 1, 2009.

All drug claims will require the submission of an accompanying 11-digit NDC. This includes claims for hemophilia factor products that are currently submitted with specific J codes.

The NDC must be submitted using the 5-4-2 format when billing with hyphens (e.g., 12345-1234-12). NDC numbers without hyphens (12345678911) will also be accepted. Please *do not* include spaces, decimals, or other characters in the 11-digit string, or the claim will be returned for correction prior to processing.

### *Electronic billing (837P)*

#### **NAIC codes**

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

# Billing & Reimbursement for Ancillary Services

If your facility is not operational on EDI for all products, please contact the EDI support group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

## ***Paper billing***

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

## **Private-duty nursing**

### ***Billing information***

AmeriHealth requires that contracting private-duty nursing providers submit their claims on a CMS-1500 form. A description of how to complete a CMS-1500 form can be found at [www.amerihealth.com/providers/claims\\_and\\_billing/claim\\_requirements.html](http://www.amerihealth.com/providers/claims_and_billing/claim_requirements.html).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- Preapproval/Precertification is required for all private-duty nursing services.
- The NPI assigned to your organization must appear on every claim.
- The procedure codes listed in this section must be used in order to ensure proper claims payment.
- Since Precertification is required for the reported service, please complete field locator 23 on the CMS-1500 form.

| Covered services |                                    |
|------------------|------------------------------------|
| Code             | Description                        |
| S9123            | Registered nurse, per hour         |
| S9124            | Licensed practical nurse, per hour |

## ***Electronic billing***

### **NAIC codes**

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

## ***Paper billing***

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.



# Billing & Reimbursement for Ancillary Services

## Hospice

### Preapproval/Precertification requirements

All Inpatient hospice services require timely Preapproval/Precertification. There is no Preapproval/Precertification requirement for home hospice services (revenue code 0651). A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

### Billing information

AmeriHealth requires all hospice claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at [www.amerihealth.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported “statement from” and “statement through” dates.
- The revenue codes listed in this section should be used to bill hospice services.
- The correct bill type, 81X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- Be sure that all the required form fields are completed.
- Be sure that all Member information is correct (e.g., date of birth, relation-to-insured code).

| Covered services |   |
|------------------|---|
| Revenue code     | Description                             |
| 0651             | Home hospice care, visit charge         |
| 0652             | Continuous care home hospice (per hour) |
| 0655             | Respite care hospice (per day)          |
| 0656             | Inpatient hospice care (per day)        |

### Electronic billing (837I)

#### NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

# Billing & Reimbursement for Ancillary Services

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

## ***Paper billing (UB-04)***

If you must submit a claim on paper, you will need to bill on a UB-04 form.

## **Independent laboratory**

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### **Preapproval/Precertification requirements**

A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

### **Billing information**

AmeriHealth requires contracting laboratory providers to submit their claims on a CMS-1500 form. A description of how to complete a CMS-1500 form can be found at [www.amerihealth.com/providers/claims\\_and\\_billing/claim\\_requirements.html](http://www.amerihealth.com/providers/claims_and_billing/claim_requirements.html).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim.
- Only those service codes specified in your Agreement will be reimbursed.

### ***Electronic billing (837P)***

#### **NAIC codes**

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

### ***Paper billing***

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

# Billing & Reimbursement for Ancillary Services

## Lithotripsy centers

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### Preapproval/Precertification requirements

A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

### Billing information

AmeriHealth requires all lithotripsy claims be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at [www.amerihealth.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf).

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported “from” and “through” dates.
- The correct revenue code assigned by AmeriHealth (0790) must be reported in order to ensure proper claim payment.
- The correct bill type, 83X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.

### *Electronic billing (837I)*

#### NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

### *Paper billing (UB-04)*

If you must submit a claim on paper, you will need to bill on a UB-04 form.

## Skilled nursing facility

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### Preapproval/Precertification requirements

Preapproval/Precertification numbers, when applicable, should appear in box 63. A list of current Preapproval/Precertification requirements by product is available in [Appendix A](#); however, these requirements vary by benefits plan and are subject to change.

# Billing & Reimbursement for Ancillary Services

## ***Billing information***

AmeriHealth requires skilled nursing facility (SNF) claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at [www.amerihealth.com/pdfs/providers/mpi/ub04\\_form.pdf](http://www.amerihealth.com/pdfs/providers/mpi/ub04_form.pdf).

Please take special note of the following guidelines:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- To expedite processing, do not submit claims until all charges are identified/included on the claim.
- A charge amount must appear in the total charge field for each line item. Lines with zero dollar charges will not be accepted. The amount billed must be greater than zero.
- Miscellaneous CPT/HCPCS codes (codes ending in “99”) are not acceptable.

## ***Electronic billing (837I)***

### **NAIC codes**

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at [www.amerihealth.com/providers/claims\\_and\\_billing/edi/forms.html](http://www.amerihealth.com/providers/claims_and_billing/edi/forms.html) for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth via your own computer system. Claims are submitted in batches and may be sent monthly. Once claims are submitted via EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

## ***Paper billing (UB-04)***

If you must submit a claim on paper, you will need to bill on a UB-04 form. In order to assure correct claims payment, use the following revenue codes when billing for services rendered:

| Revenue code           | Description                                |
|------------------------|--|
| 0121                   | Days after Medicare                        |
| 0130, 0150             | Basic SNF – Freestanding or hospital-based |
| 0120, 0191             | Subacute medical                           |
| 0129, 0199             | Subacute medical – high-cost IV drug*      |
| 0118, 0128, 0190, 0192 | Subacute rehab                             |
| 0206, 0193             | Ventilator dependent-chronic care          |
| 0200, 0194             | Ventilator dependent-active weaning        |

\*High-cost IV drug is when the cost of the drug is greater than \$100 AWP.

# Billing & Reimbursement for Ancillary Services

## *Managed care products*

The facility's per diem rate is all-inclusive for Members at a skilled or subacute level of care. Facilities are responsible for paying any subcontracted provider who furnishes ancillary services to Inpatient Members. This includes, but is not limited to, the following:

- routine diagnostic lab tests and processing
- venipuncture
- DME (except for those items set forth under the exceptions noted below)
- enteral feedings
- medical/surgical supplies
- parenteral hydration therapy
- pharmaceuticals, including IV therapies
- physical, occupational, and/or speech therapy, including supplies to support these services
- routine radiology services performed onsite at the SNF

The services itemized below should be Preapproved/Precertified by an AmeriHealth Participating Provider who will bill and be reimbursed directly for the service.

The following items are excluded under the per diem rates.

- DME:
  - customized orthotics/prosthetics
  - low air loss specialty beds/mattresses and Clinitron<sup>®</sup>/air fluidized beds consistent with CMS Group II and III requirements
  - bariatric beds
  - wound vac devices and supplies
- Other services:
  - physician services
  - MRIs, CAT scans, Doppler studies
  - emergent transportation
  - dialysis services
- blood and blood products

## **Referrals for HMO Members in long-term care/custodial-care nursing homes**

A Referral is required for ancillary services or for consultation with a specialist for Members residing in long-term care (LTC) or nursing homes. In such cases, Preapproval/Precertification Review is not required. We have established LTC panels for our PCPs who provide care in LTC participating facilities. The LTC panels do not have designated ancillary services (e.g., laboratory, physical therapy, radiology, or podiatry). The completion of a Referral is required for any ancillary service for an LTC panel Member. In addition, a Referral is required for any specialist physician consultation and/or follow-up for an LTC panel Member.

LTC panel PCPs must issue Referrals for any professional service or consultation for an LTC panel custodial nursing home Member. Examples of services that require Referrals include specialist, podiatry, physical therapy, and radiology. Participating Providers should submit Referrals in advance of the service being provided using NaviNet<sup>®</sup> or the IVR system.

## Billing & Reimbursement for Ancillary Services

Consultants and ancillary providers are encouraged to provide Referral information with the claim to assist in processing. Preapproval/Precertification Review is required only for Inpatient Admission for hospital care, SNF care, short procedure unit cases, or Outpatient surgi-center procedures.

During an approved skilled nursing care Admission, it is not necessary for the attending physician to issue a Referral. All providers giving care to the Member should use our Inpatient skilled nursing care authorization number for claims during dates of service within the skilled nursing Inpatient stay.

*Note:* Certain products have specialized Referral and Preapproval/Precertification requirements and/or benefits exemptions.

### **Part B therapy services for Medicare Advantage Members**

SNFs that provide Outpatient therapy services — physical, occupational, or speech therapy — will be reimbursed separately only for Members who reside at the facility at a custodial level of care.

*Note:* The reimbursement depends on the terms of your Agreement.