Texas Medicaid & Healthcare Partnership

Online CMS-1500 Claims Submission Provider Training Manual

November 17, 2005

Version 1.1

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1.0 Background

As of November 1, 2005, providers enrolled in Medicaid, Medicaid Managed Care, or Children Special Health Care Needs (CSHCN) Services Program, and who have a provider administrator account are allowed to submit certain Centers for Medicare and Medicaid Services (CMS)-1500 claims interactively through the Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com.

Claims submission through the TMHP website will only be available for registered users who have been issued a secure, authenticated username and password. The provider can grant claims submission permission to other users. Refer to Section 2.2 for more information.

Services eligible for portal submission include:

- Traditional Medicaid (program 100) Professional, Ambulance, and Vision services (CMS-1500 claim form)
- Medicaid Managed Care (program 200) Professional, Ambulance, and Vision services (CMS-1500 claim form)
- Children with Special Health Care Needs (CSHCN) Services Program (program 400) services (CMS-1500 claim form)

The entry fields are similar to the CMS-1500 (formerly the Health Care Financing Administration [HCFA]-1500) paper claim form to help ensure a smooth transition from paper to web-based electronic submission.

To ensure accurate processing, the claim information undergoes minor field validations before being allowed through the Electronic Data Interchange (EDI) portal. Once the claim passes the portal validation, the provider receives notice of the submission, and the claim is submitted to the Compass21 claims engine for full validation and processing.

The new web-based submission process through the portal is beneficial in many ways. It creates a secure web-based method for providers to submit electronic claims, and it decreases the provider's need to update software applications. Processing time is equivalent to electronic claims processing.

Not included in the www.tmhp.com submission functionality are:

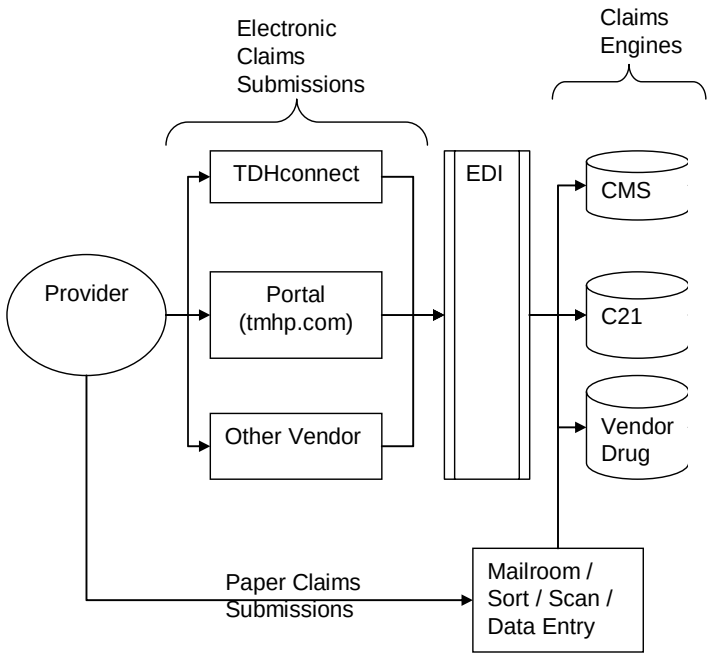
- Batch processing
- Attachments
- Prior Authorization requests
- Appeals
- Long Term Care claims
- Inpatient or Outpatient claims—HCFA-1450 (UB-92) submissions
- Family Planning claims submitted on the Family Planning Form H2017
- Texas Health Steps (THSteps) Dental Claims (2002 American Dental Association [ADA] Claim Form)

- Provider Enrollment Application and attached documents
    - Provider Contract/ Provider Agreement
    - Provider Information Form (PIF-1)
    - Principal Information Form (PIF-2)

1.1 Process Overview

Claims are submitted via the TMHP website (portal) to a front-end processor called the EDI Gateway that contains approximately 200 validation edits. The provider receives a message from EDI if the front-end edits detect an error with individual claims. The submitter receives an accepted internal control number (ICN) or an error report notification within approximately 30 seconds after submitting the claim. Figure 1 shows the process for interaction between the provider and the claims processing systems.

Figure 1: Process Flow



When starting the portal claims submission process, the submitter selects the billing provider's valid nine-digit Texas Provider Identifier (TPI) from the drop-down menu to proceed with the portal claims submission process. The drop-down menu displays only those TPIs linked to the Provider Administrator Account (see Section 2.2). A claim without the billing provider's complete TPI cannot be processed. To complete the process, each claim form must have the appropriate signatory evidence in the signature certification block by checking the "We Agree" box in the signature certification block.

Important: All required information must be included on the claim. Required fields are marked with a red dot. Adding attachments is not allowed at this time. All pertinent fields must be entered, whether or not they are designated by a red dot.

For more instructions and information about claims submission, providers and their staff are encouraged to refer to the paper claim instructions on how to complete this form provided in the Claims Filing Section of the *Texas Medicaid Provider Procedures Manual* (TMPPM) and *CSHCN Provider Manual-Part 1*.

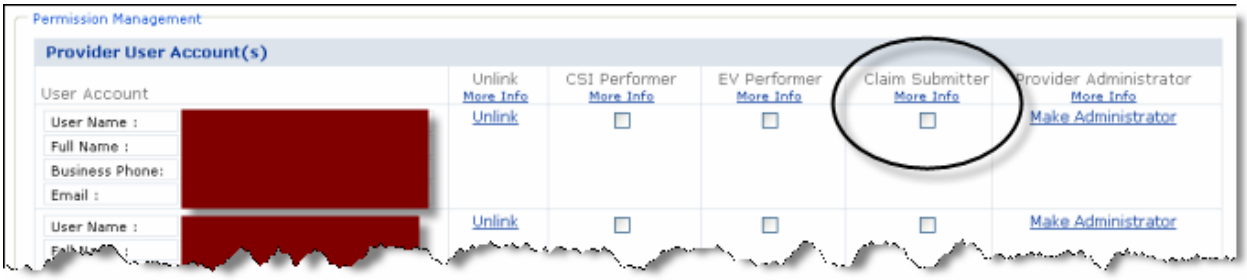
1.2 Accessing the TMHP Website and Submission Form

To access the secure pages of www.tmhp.com that contain the submission form, Texas Medicaid and CSHCN Services Program providers must create a Provider Administrator account. An *administrator* is defined as an individual provider or management-level employee assigned by a provider.

Important: *Billing services, vendors, and clearinghouses* cannot *be registered as provider administrators. If billing services, vendors, or clearinghouses wish to access user accounts on behalf of a provider, only the provider administrator can grant the appropriate access rights.*

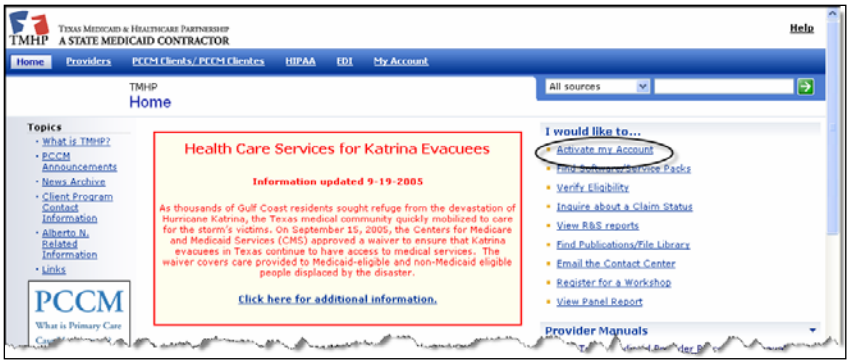
If a provider administrator account has already been established, then the ability to submit claims exists without additional permissions. The provider administrator can grant claims submission permissions to additional individual accounts. Figure 2 shows the additional permissions available through the TMHP website to allow users to submit claims.

Figure 2: www.tmhp.com Claims Submission Permissions



All new users who do not have an existing account must setup a provider administrator account to access online claim submission and other secure functions available on the website. To establish an administrator account, click **Activate My Account** on the www.tmhp.com home page (see Figure 3). Providers can call the EDI Help Desk at 1-888-863-3638 if questions arise during the account activation process.

Figure 3: www.tmhp.com Home Page



1.2.1 Account Activation

To activate an account:

1. Access the www.tmhp.com home page.
2. Click **Activate My Account**.
3. Refer to the *Texas Medicaid & Healthcare Partnership Website Security Provider Training Manual* available at www.tmhp.com for specific instructions on creating a provider administrator account and granting permissions to other users.

1.2.2 Submission Form Access

To access the online claims submission form:

1. Access the www.tmhp.com home page.
2. Click **Submit a Claim**, which is located under the “I would like to…” section in the upper right of the page.
3. Refer to Section 2.3 for instructions to fill out the claim form.

2.0 Filling Out the Form

The form is divided into two "steps." Step 1 initiates the process by verifying client and provider ID numbers. In Step 2, the claim is entered and submitted.

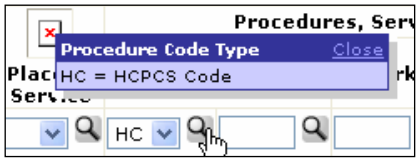
2.1 Form Maneuverability

The online claim submission form contains functions that allow for easier access to information as well as ways to enter information more quickly and efficiently:

- *Radio buttons*—Radio buttons allow the user to choose among several options. The "Yes" and "No" radio buttons on the form default to the "No" response. When the user selects the "Yes" response, the form adjusts to accommodate new fields as required by the new request.

- *Delete buttons*—Each detail line is followed by a red "X." To delete the entire detail line from the claim, click the **X**.

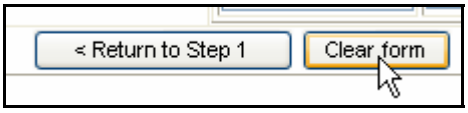
- *Magnifying glasses*—The magnifying glass next to certain fields allows the user to validate the information in the field. To access a description of the code used, click the magnifying glass next to the desired field after entering the code. A description window will appear with the definition or description of the code used.



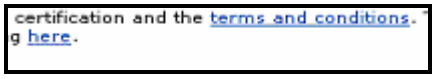
- *Drop-down boxes*—The fields containing drop-down menus will only allow information chosen from the defined list as it appears in the drop-down selection list.

- *Buttons*—The buttons at the bottom of each section or screen allow the user to proceed to the previous or next screen, add additional information, or perform a necessary or desired action.

Clicking the **Return to Step 1** button will cause all of the keyed data to be lost. To retain this information, click the **Back** button of the browser.



- *Links*—All links are indicated by blue text that is underlined. The text indicates the information available for access. Single-click on the blue underlined text to access the information.



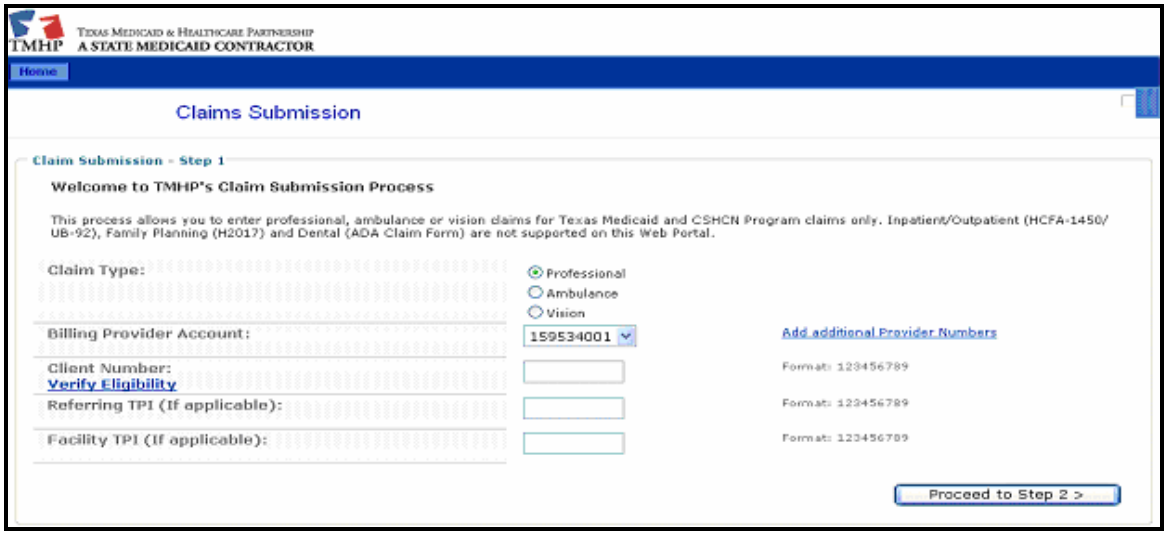
If the mouse hovers over the link, the text turns red and the underline disappears indicating the link is active.

2.2 Claim Submission–Step 1

To submit a professional CMS-1500 claim:

1. Enter the following information as prompted from the Claim Submission-Step 1 screen.

By entering a valid client number and the optional Referring and Facility TPI' s in this step, the name, address, and demographic data on file with TMHP will be autopopulated on the claim form in Step 2 to help reduce manual data entry.



a. *Claim Type*—By clicking the appropriate radio button, the submitter chooses the type of claim being submitted (Professional, Ambulance, or Vision).
b. *Billing Provider Account*—The submitter chooses the correct billing provider's valid nine-digit TPI from the drop-down menu. This field cannot be edited.

The Billing Provider Account number is a pre-set, drop-down menu selection based on the account's secure log-on administration rights for billing claims. The Billing TPIs in the drop-down box represent the only billing accounts available to the user for claims submission.

c. *Client ID*—The submitter enters the client's valid Client ID number. To aid the user in the submission process, Step 1 provides a link to the secure eligibility page of www.tmhp.com. Users can easily check client eligibility before submitting the claim by clicking **Verify Eligibility** under "Client ID."

d. *Referring TPI*—The submitter enters the referring provider's valid nine-digit TPI (only necessary if it is required in the Claims Filing section of the TMPPM and the *CSHCN Provider Manual-Part I*). A 6-digit Medicare core or 10-digit Palmetto number can be entered in Step 2 if preferred.

e. *Facility TPI*—The submitter enters the facility provider's valid nine-digit TPI (only necessary if it is required in the Claims Filing section of the TMPPM and the *CSHCN Provider Manual-Part I*). The facility name and address can be used in step 2 if the TPI is not known.

The Claim Type and Billing Provider Account fields are required to proceed to Step 2. Referring TPI and Facility TPI are only necessary when required in the Claims Filing section of the TMPPM and *CSHCN Provider Manual-Part I*. All fields must be valid to proceed to Step 2. If the Referring Provider and/or Facility Provider do not have a TPI, proceed to Step 2 and fill out the appropriate fields with the provider information. Refer to the Claim Entry Section for more information.

2. Correct any errors that appear—If the Client ID, Referring TPI, or the Facility TPI entered is invalid, the user receives an error message:

3. Click **Proceed to Step 2 >**.

2.3 Claim Submission–Step 2

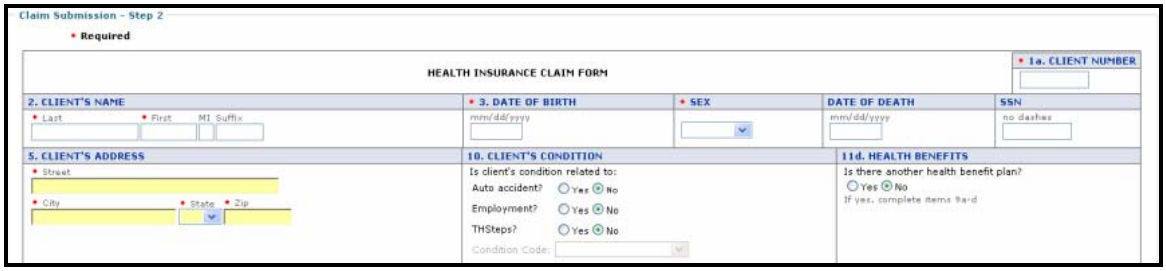
All information provided during Step 1 of the portal claims submission process is automatically populated in the appropriate fields of the claim form, including ID numbers and demographic information (name, address, and birthday).

To avoid receiving an error about client information that does not match what is in the claim system, it is important not to alter the information that has been autopopulated in the claim form. If the autopopulated client information does not match what was given to the provider, Medicaid clients should contact their case worker at their local Health and Human Services Commission (HHSC) office. CSHCN clients should contact their local Department of State Health Services (DSHS) Regional office.

Complete all of the required fields on the Claim Entry page.

All required fields are indicated by a red dot and must have data entered before the claim is submitted. Additional red dots will appear as field entries are changed to denote additional required fields when a "Yes" radio button is selected.

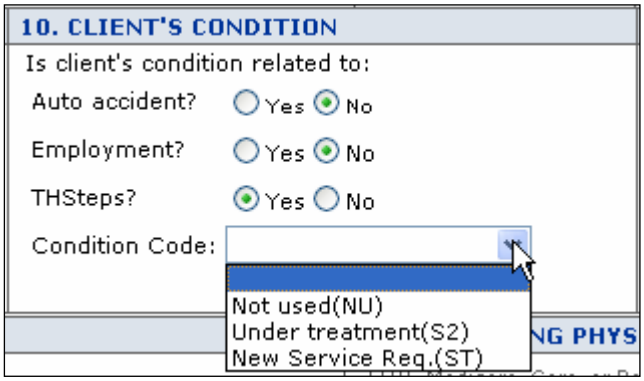
1. *Client information*—If a valid Client ID is entered in Step 1, then blocks 1 through 9 are automatically populated with the information in the claims engine system. Complete blocks 1 through 11d, and block 26 (Client Account Number at the bottom of the form).



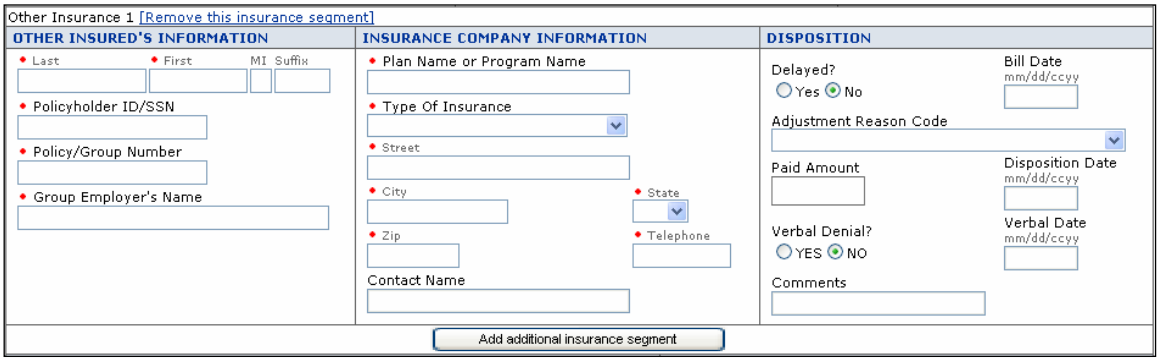
Required Fields:

- Client Number
- Client Last and First Name (automatically populated based on the Number entered in Step 1)
- Client Date of Birth (DOB) (automatically populated based on Number entered in Step 1)
- Client Sex (automatically populated based on Number entered in Step 1)
- Client Address including City, State, and ZIP code (automatically populated based on Number entered in Step 1)
- Client Account Number (block 26) (as assigned by the provider's office)

2. *Condition Codes*—If the claim is related to either an injury that has occurred due to an accident, or if the claim is being filed specific to a THSteps Medical visit, choose the appropriate radio button. This area will automatically default to no, if options are not required for specific claim. Once a specific radio button is chosen additional required areas will appear, for example:



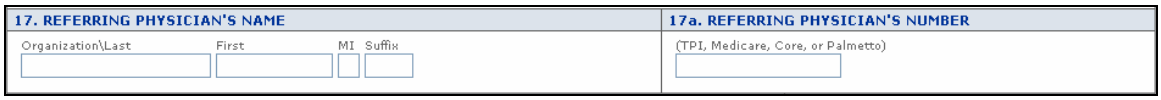
3. *Other Insurance*—To add Other Insurance information, choose the Yes radio button in field 11d and complete the fields that appear.



Disposition—a specific disposition must be included on the claim.

- *Delayed Indicator*—Radio Button is used to indicate that the provider is attempting to utilize the 110-Day Rule. Refer to the Claims Filing Section of the TMPPM and the *CSHCN Provider Manual-Part I* concerning policy for the 110-Day Rule. The provider is required to insert a Bill Date when choosing this option
- *Adjustment Reason Code*—The provider can provide an adjustment reason code. The Paid Amount and Disposition Date fields are required when choosing this option. Zero is an acceptable paid amount, if the provider did not receive a payment from the other insurance. Refer to section 7 for a listing of all of the Adjustment Reason codes.
- *Verbal Denial*—If the provider received a Verbal Denial from the other insurance, the provider can submit this information to TMHP. The contact name and comments are required. Refer to the instruction table located in section 6 for specific information required in Comments. The Comments field will allow 28 characters of space to enter information about the Verbal Denial.
- For additional other insurance segments, click the **Add additional insurance segment** button. Another segment will appear under the first. Continue to add each additional segment in this manner. The provider can supply up to three different Other Insurance segments for each claim.

4. *Referring Physician information*—Complete the appropriate provider information in blocks 17 and 17a, if the TPI was not provided in Step 1. An alternate Provider Identifier can be submitted in field 17a, such as a 6-digit Medicare core number or a 10-digit Palmetto number. Refer to the Claims Filing Section of the TMPPM and the *CSHCN Provider Manual-Part I* for more information.

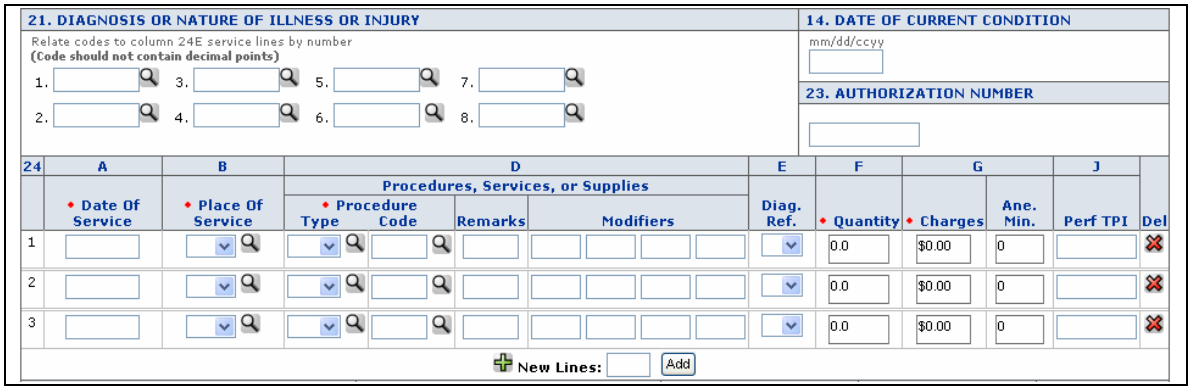


Detail Information

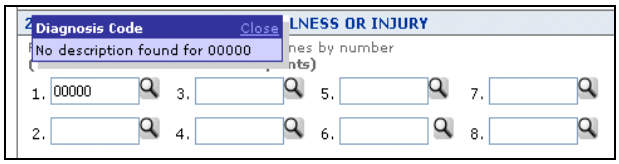
Key Points to Remember:

- No special characters are allowed in the text fields.
- Dates use the mm/dd/yyyy format.
- Place of Service (POS) is two-digits chosen from a set drop-down menu (see block 24b of the Section 2.3.2.2 Instruction Table).
- All errors must be resolved before the claim can be submitted.
- Click the magnifying glass to get additional information on specific fields.

5. *Claim Diagnosis*—Complete block 21 and submit the claim with the highest level of specificity available, complete to the five digits for each diagnosis observed, if required for a specific claim. A valid diagnosis should be entered, if required for claim, to avoid being processed without errors.



If the statement "no description found" is displayed when using the magnifying glass to verify diagnosis or procedure codes, then the code is not recognized by the claims engine.

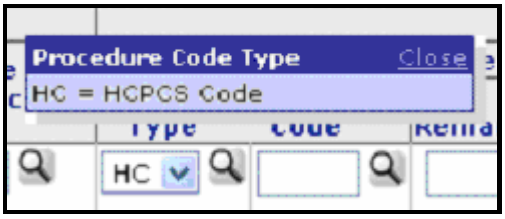


6. *Date of Current Condition*—If the services provided are accident or maternity-related, indicate the date of injury for the accident, or the date of the last menstrual period.
7. *Authorization Number*—The claim system will verify that the authorization number that was submitted corresponds to the client's account. The authorization number must be on the claim and in the client file to be processed without receiving an error.

Required Fields:

At least one complete claim detail (including: Date of Service, Place of Service, Procedure Code, Quantity, and Charges) is required.

8. *Date of Service*—Enter the date of service for each procedure provided in a mm/dd/yyyy format. Medicaid does not accept multiple ("to" or "from") dates on a single line detail. Bill only one date per line. "To" dates of service are not used on electronic claims.
9. *Place of Service (POS)* —Select the appropriate POS for each service using the electronic two-digit format located in Section 6. For Ambulance claims the POS will be the destination, for THSteps medical checkups the POS will always be 11.
10. *Procedure Type*—For Health Insurance Portability and Accountability Act (HIPAA) compliance, the provider is required to identify what type of procedure code is being submitted. Click on the magnifying glass for a description of each procedure type. For example HC is the appropriate code for a HCPCS. Refer to section 6.0 for the definition of each procedure type.

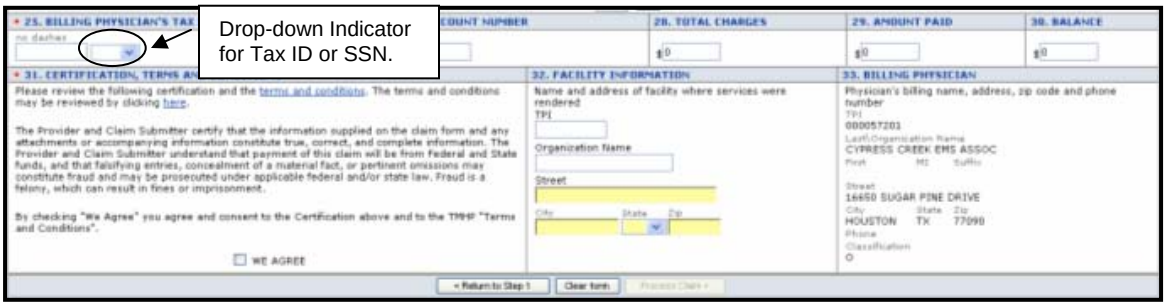


11. *Type of Service*—The provider is not required to choose a type of service for an electronic claim; the claim system will define the appropriate type of service for specific procedure codes. The claim system does require that certain procedure codes be submitted with a modifier to identify the type of service. The provider should refer to the Claims Filing Section of the TMPPM and the *CSHCN Provider Manual-Part I* for further clarification.
12. *Procedure Code*—Enter the appropriate procedure codes for all procedures/services billed. A valid procedure code is required for the claim to be processed without errors.
13. *Remarks*—For those procedure codes that require an additional code for correct processing, place the additional code that is indicated in the Claims Filing Section of the TMPPM and the *CSHCN Provider Manual-Part I,* in the remarks field of the appropriate detail.
14. *Modifier*—Enter any needed modifier codes into the Modifier fields available. Up to four individual modifier codes are allowable for a single claim detail.
15. *Diagnosis Reference*—Enter the line item reference (1, 2, 3, etc.) for each service or procedure as it relates to each International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be identified. Only one diagnosis can be referenced per procedure.

16. *Quantity Billed*—Enter the total quantity for the service. The field allows for up to two digits.
17. *Charges*—Indicate your usual and customary charges for each service listed.
18. *Anesthesia Minutes (Ane. Minutes)*—If needed, enter the anesthesia minutes in this field. A minimum quantity of 1.0 must be entered in the quantity field on anesthesia claims.

There are only three detail lines initially visible. To add additional detail lines, enter the number of lines to be added in the New Lines field, and click **Add**. A total of 28 detail lines can be included on a single claim.

19. *Performing Provider (Perf TPI)*—Members of a group practice must identify the nine-digit TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice will not appear in Block 33.
20. *Billing Physician's Tax ID*—The Tax ID or Social Security number of the provider submitting the claim. Choose the appropriate type of ID being submitted on the claim. (SSN- Social Security Number, or EIN- Employer Identification Number)

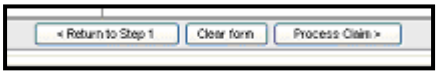


21. *Client Account Number*—The client account number field is required for HIPAA security reasons. It can be any client reference number created by the provider that is comprised of up to 15 alphanumeric characters. The information provided in this field will be referenced on the claim in the Remittance and Status (R&S) report.
22. *Charges*—The following fields can not be edited and will be populated from the information provided in the detailed fields.
    - *Total*- The system will calculate the total of all separate changes for each line item on the claim.
    - *Amount Paid*- Data is populated from the other insurance information supplied in field 11.
    - *Balance*- The system will subtract the amount paid from the total for the amount in this field.
23. *Certification, Terms and Conditions*—Provider and Claims Submitter must review and agree to all Certifications and Terms and Conditions with each claim form

submission. *The provider and claims submitter are held accountable for their declarations when they acknowledge their agreement and consent.* The Terms and Conditions referred to in this field are similar to the terms and conditions that are located on the back of the paper CMS-1500 claim form. The provider must agree to the Certification and Terms and Conditions to continue with the submission of the claim.

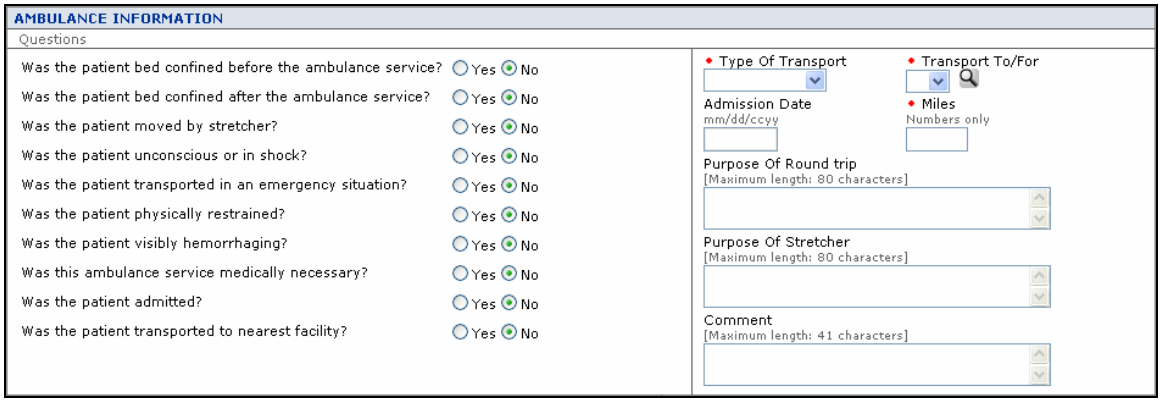
24. *Facility Information*—Complete the appropriate provider information in block 32 if the TPI was not provided in Step 1. A TPI is not required in this field if not available.
25. *Billing TPI*—The field is autopopulated from the TPI in Step 1. If the billing name, address, and phone number are not correct, call TMHP Provider Enrollment at 1-800-925-9126 or TMHP-CSHCN Provider Enrollment at 1-800-568-2413.

After the **I Agree** radio button has been selected the **Process Claim** button will become available to process the claim.



2.3.1 Ambulance Claim

When the Ambulance radio button is selected during Step 1, the Step 2 claim form will reflect the fields specific to Ambulance claims. All required fields are indicated by a red dot.



1. Use the radio buttons under “Questions” to indicate the nature of the client’s condition.
2. *Type of Transport*—indicates the nature of the transport:
   - *Initial trip*—The first trip from origin to destination
   - *None*—No transport
   - *Return*—The final trip from destination to origin (reserved for nonemergency transports as described in the TMPPM and the *CSHCN Provider Manual-Part I*)
   - *Transfer*—The interim trip from facility to facility
   - *Round*—The entire trip from origin to destination and from destination back to origin (reserved for nonemergency transports as described in the Claims Filing section of the TMPPM and the *CSHCN Provider Manual-Part I*)
3. *Transport To/For*- Choose from letters A through D as described below:

   A = To nearest facility for symptoms and/or complaints

   B = For the benefit of preferred physician

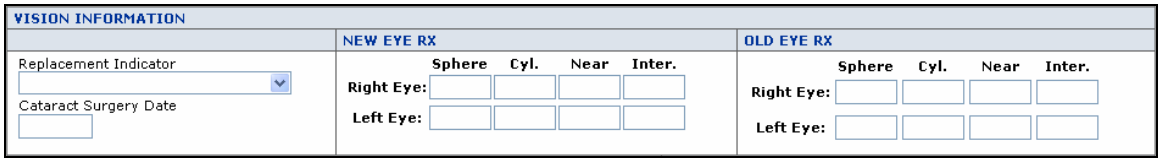
   C = For the nearness of family members

   D = For the care of a specialist
4. *Admission Date*—Enter the date the client was admitted to the hospital (if the radio button states “yes”).
5. *Miles*—Indicate the loaded miles for the transport.
6. *Purpose of Round Trip*—Comments field reserved for the narrative that indicates the purpose for the round trip. It is required, if round trip is selected under type of transport.

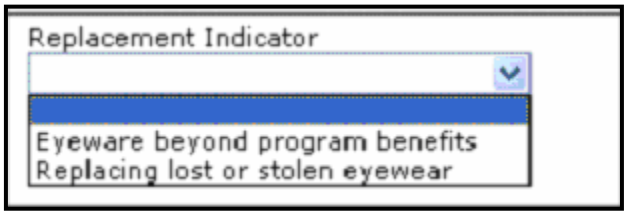
7. *Purpose of Stretcher*—Comments field reserved for the narrative that indicates the purpose for the use of a stretcher (if the radio button states "yes"). This field is also approved for other necessary comments not related to the stretcher purpose. See the *Texas Medicaid Bulletin* no.189, page 20, or the *CSHCN Provider Bulletin* no.55, page 11, for more information
8. *Comment*—Comments field reserved for the narrative that indicates the acuity of the client, including blood pressure, respiratory rates, temperature, blood glucose levels, Glasgow Coma Score, etc. as recorded on the ambulance run sheet, as well as any other comments relevant to the processing of the claim as indicated in the TMPPM and the *CSHCN Provider Manual-Part I*.

2.3.2 Vision Claim

When the Vision radio button is selected during Step 1, the Step 2 claim form will reflect the fields specific to Vision claims.



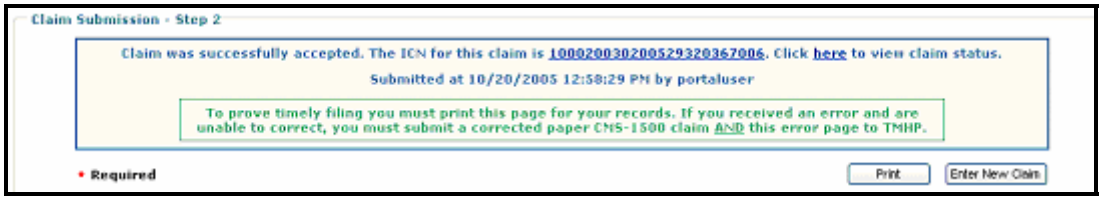
1. *Replacement Indicator*-If the claim is being submitted because the eyewear was lost or destroyed, or if the eyewear is beyond the program benefits, this information should be indicated in the field.



2. *Cataract Surgery Date*—Enter the date of the cataract surgery if applicable.
3. *New Eye RX*—Enter the information for the new eye prescription for both the right eye and the left eye as applicable.
4. *Old Eye RX*—Enter the information for the old eye prescription for both the right eye and the left eye as applicable (for comparison purposes).

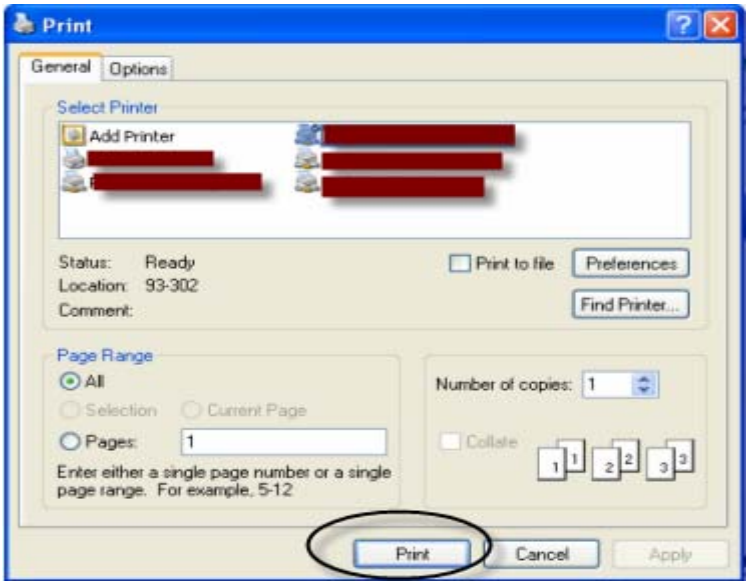
3.0 Claim Response

- Provider Notification: *Claim Accepted*



If the claim is accepted through EDI into the Compass21 claims engine, the provider receives a confirmation indicating the ICN assigned to the claim by TMHP. The ICN will appear at the top of the claim. The acceptance message will also include the date and time the claim was submitted, and the option to print the claim for record-keeping and documentation purposes. *It is recommended that providers print this form for their record keeping.*

A separate print dialog box will open. Click **Print**.



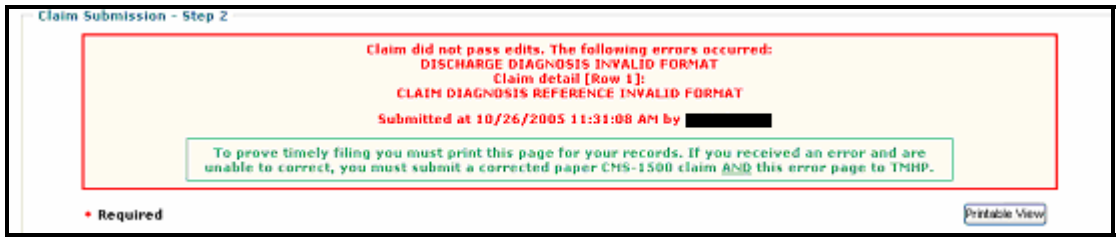
Print the claim *immediately* after receiving the submission or error notification. The option to print will not be available after exiting the current claim screen.

- *Claim Status Inquiry*- The provider has the ability to check the status of the claim by clicking on the 24-digit claim number. The provider will then be forwarded to the Claim Status Inquiry on the portal.
- Provider Notification: *Claim Received Error*

1. Make corrections as prompted by online edits. Many pages perform online edits or validations as information is entered into the fields. If the data for required fields is missing or invalid, the system will display an error message summarizing the front-end (validation) error in one of two places:

   - Near the field—The detail error message is displayed after tabbing to the next field.

   - Top of the page—The header error message is displayed after selecting **Process Claim**.



2. If the claim is rejected, the provider receives an error report notification at the top of the page indicating the errors that were encountered upon entering the claims engine system. The error message will also include the date and time the claim was submitted (for proof of timely filing if necessary), and the option to print the claim for record-keeping and documentation purposes. The submitter may correct the errors at this time.
3. If the submitter chooses to submit the claim on paper at any time during the submission process, this error report can be printed out and submitted with the CMS-1500 claim form as proof of timely filing. This error report does *not* take the place of the claim form and cannot be used in the place of the CMS-1500 when submitting the paper claim. Please see section 3.1 for instructions concerning submitting a paper claim after receiving a Portal Error Report (if proof of timely filing is required).

The Process Claim button will only display one header online error message at a time. Continue to click **Process Claim** after correcting each error, until the ICN of the accepted claim appears at the top of the screen. The claim grays out and can then be printed.

4. The user is able to correct fields with errors if necessary, and can click **Process Claim** again. The form cannot be retrieved at a later time, so it is important to remember to print before going to the next claim for submission. If the error denotes information that cannot be corrected, then print the form immediately to submit for timely filing.
5. After all data entry is completed and all errors have been corrected, the user submits the claim by clicking **Process Claim** at the bottom of the page. The Process Claim button is available only after all of the required fields have been completed. To cancel the claim instead of submitting it, click **Clear Form**. *Providers must retain all claims and file transmission records.*

Print the claim *immediately* after receiving the submission or error notification. The option to print will not be available after exiting the current claim screen.

3.1 Guidelines for Submitting a Rejected Claim

Providers are encouraged to correct all error messages and resubmit the claim as many times as necessary to complete the submission electronically. If it becomes necessary to submit the claim via paper, refer to the TMPPM and the *CSHCN Provider Manual-Part I* for appeal instructions, keeping in mind the following guidelines:

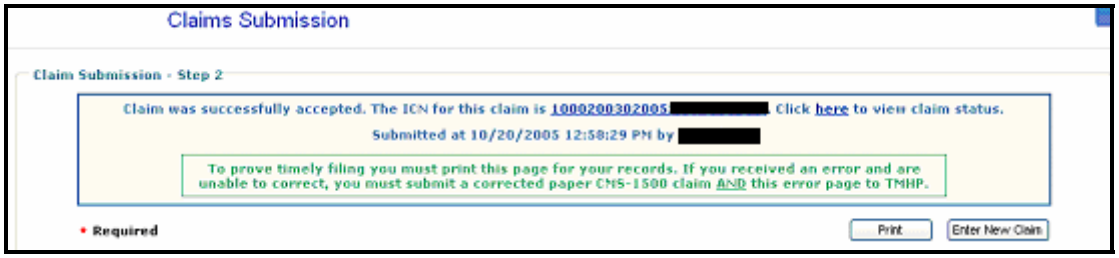
1. Print all error reports *immediately* upon receiving them, and submit them (if necessary for proof of timely filing) with the CMS-1500 claim form.
2. Submit the corrected claim on a CMS-1500 claim form. The submission will be returned with a cover letter to the provider if the completed CMS-1500 claim form is not attached. TMHP will not process the claim without a CMS-1500 claim form.
3. Submit all documentation necessary for accurate and timely claims processing.

Important: Providers receiving TMHP errors must submit the corrected claim within 120 days of the submission date listed on the printed error report screen.

4.0 Printing a Claim or Error Report

To print a copy of the claim after submission:

1. Click **Print** at the top right side of the screen.



If the claim has received an error message from EDI and the submitter chooses to submit the claim via paper instead of correcting the errors electronically, click the **Printable View** button to change the screen to a printable version. Click **Print** from the resulting screen to print the error report.

2. A separate print dialog box will open. Click **Print**.

Print the claim *immediately* after receiving the submission or error notification. *The option to print will not be available after exiting the current claim screen.* The current claim data will be lost if "Enter New Claim" is selected.

5.0 Trouble-shooting: Online Error Messages

Online Error Message	Description / Instructions
Account number required	The Account number field (block 26) is a required field. Please enter the client's account number assigned by the provider's office.
Account number should only contain alphanumeric characters	Enter alphanumeric characters only. No special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Admission date cannot be earlier than date of birth	Dates cannot be before the date of birth or after the date of death.
Admission date cannot be prior to date of birth	Dates cannot be before the date of birth or after the date of death.
Admission date is required	Enter the date of the hospital admission. This is a required field.
Ambulance type required	Enter the type of ambulance transport (initial, none, round trip, transfer, or return).
At least one detail is required	Enter at least one full detail including date of service, place of service, procedure code, quantity, and charges.
Claim detail should have references to diagnosis codes under column 21.	Enter at least one valid diagnosis code (including 3- to 5-digit specificity according to the diagnosis coding manual and the TMPPM and the *CSHCN Provider Manual-Part I*).
Authorization number must be 10 digits	All valid Texas Medicaid and CSHCN authorization numbers are 10 digits in length. Enter the full valid authorization code as provided by the Texas Medicaid or CSHCN Prior Authorization Department.
Bill date cannot be prior to date of birth	Dates cannot be before the date of birth or after the date of death.
City required	Enter the city. This is a required field.
City should only contain alpha characters and be at least 2 characters in length.	Enter alpha characters only. No numeric or special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Claim detail (Row #):	The error occurs in the indicated row number of the claim details section. The specific error follows the (Row #) tag.
Claim detail (Row #): Charges cannot exceed $9,999,999.99	The monetary charge for the service billed in the indicated row number of the claim details cannot exceed $9,999,999.99.

Claim detail (Row #): Date of service required	The date of service is missing from the indicated row number of the claim details. Enter a valid date of service (cannot be a future date).
Claim detail (Row #): Diagnosis Reference required	The indicated row number requires a diagnosis be referenced to the service. Choose a diagnosis reference from the drop-down menu.
Claim detail (Row #): Modifiers must be 2 characters	The modifier(s) entered in the indicated row number of the claim details must be two characters in length (no special characters allowed).
Claim detail (Row #): Place of Service required	Each detail must contain a place of service code. The Place of Service is missing from claim detail in the indicated row number. Please choose a place of service from the drop-down menu.
Claim detail (Row #): Procedure Code must be between 3-5 characters	The procedure code must be five characters in length. Refer to the TMPPM and the *CSHCN Provider Manual-Part I* for valid procedure codes.
Claim detail (Row #): Procedure Code required	Each detail must contain a procedure code. The procedure code is missing from claim detail in the indicated row number. Please enter a valid procedure code.
Claim detail (Row #): Quantity > 0 is required	The quantity or number of services is required in claim detail in the indicated row number. Enter a number greater than 0 to indicate quantity or number of services.
Claim detail (Row #): Quantity cannot exceed 999.9	The quantity entered in the indicated row number of the claim details cannot exceed 999.9.
Claim detail (Row #): Type of Procedure Code required	Indicate the source for the code being submitted (CMS, etc.)
Claim did not pass edits. The following errors occurred:	Indicates an error occurred after selecting **Submit Claim**. The specific error follows the introduction tag.
Claim was successfully accepted. The ICN for this claim is (ICN)	Indicates that the claim was submitted and accepted into the claims engine system. The ICN can be used to check the status of the claim through www.tmhp.com.
Client number could not be validated	The client number is in the correct format, but is not recognized as belonging to any Texas Medicaid or CSHCN clients. Please verify the number and correct as appropriate.
Client number must be 9 digits	The client's number must be 9 digits in length.
Client number required	Enter a valid client number. This is a required field.
Comments should not exceed 41 characters	This field will only allow 41 characters. No special characters allowed.

Comments should only contain alphanumeric characters	Enter alphanumeric characters only. No special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Contact name should only contain alpha characters	Enter alpha characters only. No numeric or special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Date of birth should be a valid date and cannot be a future date	Dates cannot be in the future. Enter a past or current date.
Date of birth cannot be after date of death	Dates cannot be before the date of birth or after the date of death.
Date of birth required	Enter the date of birth. This is a required field.
Date of current condition cannot be prior to date of birth	Dates cannot be before the date of birth or after the date of death.
Date of death should be a valid date and cannot be a future date	Dates cannot be in the future. Enter a past or current date.
Date of service cannot be prior to date of birth	Dates cannot be before the date of birth or after the date of death.
Diagnosis code must be between 3-5 characters	Enter a valid diagnosis code (no fewer than three characters, no more than five characters). All diagnosis codes must be coded according to the diagnosis coding manual and the TMPPM and the *CSHCN Provider Manual-Part I*.
Diagnosis codes should only contain alphanumeric characters	Enter alphanumeric characters only. No special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Disposition date cannot be prior to date of birth	Dates cannot be before the date of birth or after the date of death.
Employee name should only contain alpha characters	Enter alpha characters only. No numeric or special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Facility name should only contain alphanumeric characters	Enter alphanumeric characters only. No special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).

Facility TPI could not be validated. Update or delete to continue.	The Facility TPI is in the correct format, but is not recognized as belonging to any Texas Medicaid or CSHCN providers. Please verify the number and correct as appropriate.
First name required	Enter the first name as prompted. Required field.
First name should only contain alpha characters	Enter alpha characters only. No numeric or special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Gender required	Enter the gender as prompted. This is a required field.
Group number should contain only alphanumeric characters	Enter alphanumeric characters only. No special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Invalid Character	The character used is invalid for the field.
Last name required	Enter the last name as prompted. This is a required field.
Last name should only contain alpha characters	Enter alpha characters only. No numeric or special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Left eye cylinder cannot contain any special characters other than + - .	No special characters allowed (! @ # $ % ^ & * ( ) _ = | \ ~ ` , ? / < > [ ] { }) other than + (positive) or – (negative) and . (period).
Left eye inter cannot contain any special characters other than + - .	No special characters allowed (! @ # $ % ^ & * ( ) _ = | \ ~ ` , ? / < > [ ] { }) other than + (positive) or – (negative) and . (period).
Left eye near cannot contain any special characters other than + - .	No special characters allowed (! @ # $ % ^ & * ( ) _ = | \ ~ ` , ? / < > [ ] { }) other than + (positive) or – (negative) and . (period).
Left eye sphere cannot contain any special characters other than + - .	No special characters allowed (! @ # $ % ^ & * ( ) _ = | \ ~ ` , ? / < > [ ] { }) other than + (positive) or – (negative) and . (period).
MI should only contain alpha characters	Enter alpha characters only. No numeric or special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` , ? / < > [ ] { }).
Miles required	Enter the loaded ambulance miles traveled according to the ambulance run sheet.
Miles should be numeric and cannot exceed 999	Enter the loaded ambulance miles in digits that do not exceed 999.
Name and address information required.	If Facility TPI is entered, the Organization name and full address become required.
Special characters ^ * : ~ ‘ < > not allowed	Special characters include: ! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }

Other insurance (Row #): Address is required	The address is required for the insurance information entered in Row # of the other insurance segments.
Other Insurance (Row #): Bill date is required	If the other insurance disposition is delayed, the date the other insurance company was billed is required to invoke the 110-day rule. Enter the date the other insurance company in the indicated row number was billed for the current services.
Other insurance (Row #): City is required	The city is required for the insurance information entered into the indicated row number of the other insurance segments.
Other Insurance (Row #): Comments is required	When documenting a verbal denial, comments are required. Enter the comments for the verbal denial segment into the indicated row number. See the TMPPM and the *CSHCN Provider Manual-Part I* for instructions concerning verbal denials.
Other Insurance (Row #): Contact name is required	The name of the contact person at the other insurance company is required when documenting a verbal denial. Enter the name of the person spoken to in this field in the indicated row number.
Other Insurance (Row #): Disposition date is required	The date of the other insurance explanation of benefits (EOB) is required for proof of timely filing. Enter the date of the other insurance EOB in the indicated row number.
Other Insurance (Row #): Disposition requires either a delay or an adjustment reason code	The claim is suspected to be past the filing deadline. Enter a reason for the delay or enter the appropriate adjustment reason code.
Other insurance (Row #): Group employer's name is required	The group employer's name is required for the insurance information entered in the indicated row number of the other insurance segments.
Other insurance (Row #): Group number is required	The group number is required for the insurance information entered in the indicated row number of the other insurance segments.
Other insurance (Row #): Insured's first name is required	The insured's first name is required for the insurance information entered in the indicated row number of the other insurance segments.
Other insurance (Row #): Insured's last name is required	The insured's last name is required for the insurance information entered in the indicated row number of the other insurance segments.
Other Insurance (Row #): Paid amount cannot exceed $9,999,999.99	The amount indicated as paid by the other insurance company in the indicated row number cannot exceed $9,999,999.99.
Other Insurance (Row #): Paid Amount is required	Enter the amount the other insurance company paid towards the services billed. Required field when

	adjustment reason code indicates a payment was made.
Other insurance (Row #): Plan name is required	The name of the other insurance plan used by the client is required for the insurance information entered in the indicated row number of the other insurance segments.
Other insurance (Row #): Policy holder SSN is required	The Social Security number (SSN) of the policy holder is required for the insurance information entered in the indicated row number of the other insurance segments.
Other insurance (Row #): State is required	The 2-character state abbreviation is required for the insurance information entered in the indicated row number of the other insurance segments.
Other insurance (Row #): Verbal date is required	When documenting a verbal denial, the date the verbal denial was given is required for the insurance information entered in the indicated row number of the other insurance segments.
Other insurance (Row #): ZIP is required	The ZIP code of the other insurance company address is required for the insurance information entered in the indicated row number of the other insurance segments.
Phone number must be 10 digits	All phone numbers require 10 digits: 3-digit area code and 7-digit phone number (123-456-7890)
Plan name should only contain alpha characters	Enter alpha characters only. No numeric or special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Purpose of round trip required	If the ambulance transport is from home to doctor's office and then from doctor's office back home, enter the reason for the round trip.
Purpose of round trip should not exceed 80 characters	The round trip comments field will only allow 80 characters (including spaces).
Purpose of stretcher cannot contain special characters other than -?#_	No special characters allowed other than the following - ? # and _ These are not allowed ! @ $ % ^ & * ( ) + = | \ ~ ` . , / < > [ ] { }

Purpose of stretcher required	If the ambulance trip required the use of a stretcher, enter the reason for the use of the stretcher. This field has also been approved for documenting other necessary comments such as acuity of the client, etc.
Purpose of stretcher should not exceed 80 characters	The purpose of stretcher comments field will only allow 80 characters (including spaces).
Referring TPI could not be validated. Update or delete to continue.	The referring TPI is in the correct format, but is not recognized as belonging to any of the Texas Medicaid or CSHCN providers. Please verify the number and correct as appropriate.
Referring TPI required	The referring TPI is missing. After entering a referring provider name, the referring TPI becomes a required field.
Remarks should only contain alphanumeric characters	Enter alphanumeric characters only. No special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Right eye cylinder cannot contain any special characters other than + - .	No special characters allowed (! @ # $ % ^ & * ( ) _ = | \ ~ ` , ? / < > [ ] { }) other than + (positive) or – (negative) and . (period).
Right eye inter cannot contain any special characters other than + - .	No special characters allowed (! @ # $ % ^ & * ( ) _ = | \ ~ ` , ? / < > [ ] { }) other than + (positive) or – (negative) and . (period).
Right eye near cannot contain any special characters other than + - .	No special characters allowed (! @ # $ % ^ & * ( ) _ = | \ ~ ` , ? / < > [ ] { }) other than + (positive) or – (negative) and . (period).
Right eye sphere cannot contain any special characters other than + - .	No special characters allowed (! @ # $ % ^ & * ( ) _ = | \ ~ ` , ? / < > [ ] { }) other than + (positive) or – (negative) and . (period).
SSN must be 9 digits	Enter a valid 9-digit SSN.
Special characters ^ * : ~ ‘ & < > not allowed.	These characters are not allowable entries in any field.
State required	Choose a valid 2-character state abbreviation from the drop-down menu.
Street required	Enter a valid street name.
Street should only contain alphanumeric characters	Enter alphanumeric characters only. No special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).
Suffix should only contain alphanumeric characters	Enter alphanumeric characters only. No special characters allowed (! @ # $ % ^ & * ( ) _ - + = | \ ~ ` . , ? / < > [ ] { }).

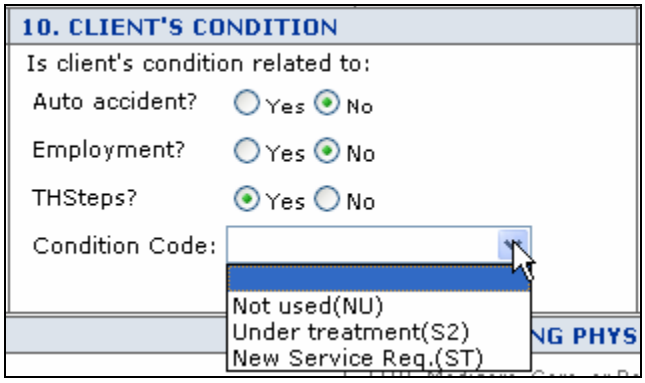
Surgery sate cannot be prior to date of birth	Dates cannot be before the date of birth or after the date of death.
Tax ID must be 9 digits	Enter a valid 9-digit Tax ID number.
Tax ID required	The Tax ID is required for accurate processing. Enter a valid 9-digit Tax ID number.
Tax ID type required	Choose the type of ID entered in the Tax ID field: SSN or EIN (Employer Identification Number)
TPI must be 9 digits	All TPI numbers must be 9 digits. Enter both the base and the suffix.
Transport to/for required	Enter the appropriate ambulance transport modifier. A = To nearest facility for symptoms and/or complaints. B = For the benefit of preferred physician. C = For the nearness of family members. D = For the care of a specialist.
Unable to process claim at this time. An error has been logged	A system error has been encountered during claim transmission; submission was unsuccessful. Try submission again at a later time.
Verbal date cannot be a future date	Dates cannot be in the future. Enter a past or current date.
Verbal date cannot be prior to date of birth	Dates cannot be before the date of birth or after the date of death.
When field 11d is marked as Yes, other insurance information is required	Enter all required other insurance information if applicable. If not applicable, click **No** for 11d, Health Benefits, to disable the other insurance segment(s).
ZIP code must be 5 digits or in the 5-4 format	Enter the valid 5-digit ZIP code (with or without the 4-digit postal code).
ZIP required	Enter the valid ZIP code. Required field.

6.0 Instruction Table

The claim fields are navigated by using the tab key or clicking on each field. The submitter completes the fields as instructed in the following table.

The table numbering is ordered according to tab order, not chronological order.

Block No.	Description	Guidelines
1a	Client Number	Enter the client's nine-digit client number from the Eligibility Identification Form. (Automatically populated from Step 1)
2	Client's name	Enter the client's last name, first name, middle initial, and suffix as printed on the Eligibility Identification Form. (Automatically populated from Step 1)
3	Client's date of birth	Enter numerically the month, day and year (mm/dd/yyyy) the client was born. (Automatically populated from Step 1)
	Client's sex	Indicate the client's sex by selecting the appropriate choice from drop down menu. (Automatically populated from Step 1)
	Client date of death	Enter the numerical month, day, and year (mm/dd/yyyy), if applicable to claim.
	Client SSN	Enter the client's SSN, if known (Automatically populated from Step 1).
5	Client's address	Enter the client's complete address as described (street, city, state, and ZIP code). (Automatically populated from Step 1)

<table>
<tr><td rowspan="2">10</td><td>Was condition related to:
A) Auto Accident
B) Employment
C) THSteps</td><td>Indicate by checking the appropriate box. If the THSteps indicator is changed to “yes”, an additional THSteps Condition code selection becomes required.
 
</td></tr>
<tr><td colspan="2">If THSteps is changed to “yes”, select from the appropriate Condition Codes:
NU (Not Used)–Indicates the client had a normal screening; an abnormal screen without treatment; an abnormal screen initiated treatment; or was referred to another health agency or to family planning.
S2 (Under Treatment)–Indicates that the client’s screen was abnormal, but the condition is under treatment.
ST (New Services Requested)–Indicates new services requested, such as when the client was referred to the Primary Care Physician (PCP) or to a specialist.</td></tr>
<tr><td>11d.</td><td>Is there another Health Benefit? :</td><td>Response defaults to “no.” If applicable, change the response to “yes” and complete section 9a which appears when “yes” is selected.</td></tr>
</table>

9 a - d.	Other health insurance	Segment one is for the Other Insured's information. If applicable, complete the Other Insured's full name; Policy Holder Number or SSN; Policy or Group Number, and the Other Insurance Group Employer/Company Name.
	Segment two is for the Insurance Company information. If applicable, complete the Other Insurance Company, the Plan Name or Program Name (Name of Insurer), the Type of Insurance (such as Commercial Insurance), and the full address of the Insurer.	
	• Segment three is for the Other Insurance Disposition information. • If other insurance resource delays and does not reply (see the Claims Filing section of the TMPPM and the *CSHCN Provider Manual-Part I* for instructions concerning the 110-Day Rule), for "Delayed?", enter "yes" and enter the Bill Date. • If an Adjustment Reason Code is applicable, select it and enter the Disposition Date and Paid Amount. • If another insurance resource has been billed and responded, enter Insurance Company Name, Address, Disposition Date, and Paid Amount. • If a verbal denial was received from the other insurer, enter Verbal Denial "yes" and enter the date they were contacted in the Verbal Date field. Enter the Insurance Company Name, Address, Contact Name, and Comment regarding the conversation. Refer to the Claims Filing section of the TMPPM and the *CSHCN Provider Manual-Part I*. There is space for 28 characters in the comments field.	
	Add Additional Insurance Segment	Additional Insurance segments can be added to the claim by clicking on this link. Up to three Other Insurance segments can be submitted with a single claim form.
14.	Date of Current Condition	Enter the date of onset for the current condition, illness, or therapy.
17.	Referring Physician's Name	If required by the type of claim, enter a referring or primary care physician's full name.
17a.	Referring Physician's TPI	If required enter the Referring Physician's TPI as a 9-digit ID or a 6-digit Medicare core number or a 10-digit Palmetto number. (Refer to the Claims Filing section of the TMPPM and the *CSHCN Provider Manual-Part I* for more information).

<table>
<tr><td>21.</td><td>Diagnosis or Nature of Illness or Injury</td><td>At least one diagnosis code is required for professional claim submission. In the Diagnosis field, enter the ICD-9-CM code to the highest level of specificity.
To help determine if the code selected is accurate, enter the code in the field and click on the magnifying glass to retrieve the Diagnosis Code Description.
More than one diagnosis code may be entered on the claim.</td></tr>
<tr><td>23.</td><td>Authorization Number</td><td>Enter the Prior Authorization Number (PAN) issued by TMHP, if applicable.</td></tr>
<tr><td>24A.</td><td>Date of service (DOS)</td><td>Enter the date of service for each procedure provided in an mm/dd/yyyy format if entered manually.</td></tr>
<tr><td>24B.</td><td>Place of service (POS)</td><td>Select a two-digit place of service from the drop-down menu.
To help determine if the POS selected is accurate, select a POS number from the drop down and click on the magnifying glass to retrieve the Place of Service description for validation.
Ambulance-the POS for all ambulance transfers will be the destination.
Place of Service (POS) conversion chart:
<table>
<tr><th>2-DIGIT NUMERIC CODE</th><th>1-DIGIT NUMERIC CODE</th></tr>
<tr><td>11, 65, 71, 72</td><td>1</td></tr>
<tr><td>22, 23, 24, 62</td><td>5</td></tr>
<tr><td>21, 51, 52, 55, 56, 61</td><td>3</td></tr>
<tr><td>81</td><td>6</td></tr>
<tr><td>25</td><td>7</td></tr>
<tr><td>33</td><td>8</td></tr>
<tr><td>31, 32, 54</td><td>4</td></tr>
<tr><td>12</td><td>2</td></tr>
<tr><td>26, 24, 53, 99</td><td>9</td></tr>
</table></td></tr>
<tr><td>24D.</td><td>Procedure Code ID and Procedure Code</td><td>Enter the appropriate Procedure Code ID for services billed, by using the drop down menu to select the type of procedure code (HC– Health Care Common Procedure Coding System [HCPCS]; IV–HIEC; N1 thru N4–National Drug Code specific format; ZZ–Mutually Defined). Click on the magnifying glass to confirm the description.
Enter 5-digit alphanumeric Procedure Code in field. Click the magnifying glass to confirm description.</td></tr>
<tr><td>24D.</td><td>Remarks</td><td>For those procedure codes that require an additional code for correct processing, place the additional code in the remarks field</td></tr>
</table>

		of the appropriate detail, as indicated in the Claims Filing section of the TMPPM and the *CSHCN Provider Manual-Part I*.
24D.	Modifiers	Enter any needed modifier codes into the Modifiers fields available. Up to four individual modifier codes are allowable for a single claim detail.
24E.	Diagnosis Reference	Enter the line item reference (1 through 8) for each service or procedure as it relates to each diagnosis code identified in Block 21. If a procedure is related to more than one diagnosis, the primary diagnosis to which the procedure is related must be the one identified. Reference to more than one diagnosis per detail is not allowed. Do not enter more than one reference per procedure. This could result in denial of the service. Refer to the Claims Filing section of the TMPPM and the *CSHCN Provider Manual-Part I* for more information.
24F.	Quantity	Enter the total quantity for the procedure. The field allows for up to two digits.
24G.	Charges	Enter the cost for the procedure performed on a single day. Cost must include 2 decimal places. The maximum total allowable is $9,999,999.99 Total Charges are automatically calculated by the system in field number 28, Total Charges.
24G.	Anesthesia Minutes	If needed, enter anesthesia minutes (Ane. Min.).
24J.	Performing TPI	Members of a group practice must identify the nine-character TPI of the provider within the group who performed the service.
	Detail line delete key	Select this red “X” to delete entire row of detail field entries if necessary.
25.	Billing Physician’s Tax ID	Enter the Billing Physician Tax ID as either an Employer ID (EIN) or SSN while selecting the corresponding ID type in the drop down.
26.	Client's account number	Required data. Any alpha/numeric characters (up to 15 digits) created by the provider as a client reference number. This block is referenced on the Remittance and Status (R&S) report.
28.	Total charge	Field cannot be edited. The system will calculate the total of all separate charges for each line item on the claim. The maximum total allowable is $9,999,999.99.
29.	Amount paid	Field cannot be edited. Data is autopopulated from Other

		Insurance information entered in Field #11.
30.	Balance	Field cannot be edited. The system will subtract Block 29 from Block 28 and enter the balance.
31.	Certification, Terms and Conditions	The provider and claims submitter consent to the certificate and TMHP terms and conditions and privacy policy as part of the submission process with each claims submission. If agreed, check the “We agree” box to proceed with processing the claim. This agreement must occur with each claim submitted.
32.	Name and address of facility where services were rendered, if other than home or office	If services were provided in a place other than the client's home or the provider's office, such as hospital, birthing center or nursing facility, enter the Provider Facility Name, Address, and ZIP code and the nine-digit TPI of the facility where the service was provided (if a TPI is available).
33.	Billing Provider Org/Name, address, ZIP code and telephone number	The Billing Provider information is autopopulated into field #33 from Step 1. This information is established with the secure log in and cannot be changed on the form. If there are updates needed to this information, please call the TMHP EDI help desk at 1-888-863-3638 from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

7.0 Adjustment Reason Codes for Other Insurance

Code	Adjustment Reason Definition
1	Deductible Amount
100	Payment made to patient/insured/responsible party.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Denied. Related service was not paid or identified on the claim.
108	Payment reduced because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor.
113	Payment denied. Service was provided outside the US or result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. Advance indemnification notice did not comply.
117	Payment adjusted. Transportation is only covered to the closest facility.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period has been reached.
121	Indemnification adjustment.
122	Psychiatric reduction.
125	Payment adjusted due to a submission/billing error(s).
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
128	Newborn's services are covered in the mother's Allowance.
129	Payment denied - Prior processing information appears incorrect.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim Adjusted. Plan procedures of a prior payer were not followed.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Taxes.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142	Claim adjusted by the monthly Medicaid patient liability amount.
144	Incentive adjustment, e.g. preferred product/service.
2	Coinsurance Amount
23	Paid by another payer.
24	Capitation agreement/managed care plan.

Code	Adjustment Reason Definition
25	Payment denied.
26	Expenses prior to coverage.
27	Expenses after coverage terminated.
29	Filing time limit expired.
3	Co-payment Amount
30	Not met eligibility, spend down, waiting, or residency.
31	Not our insured.
32	Not eligible dependent.
33	Claim denied. No dependent coverage.
34	Claim denied. No newborn coverage.
35	Benefit maximum has been reached.
38	Services not by designated providers.
39	Denied at authorization/pre-certification time.
40	Charges do not meet qualifications for emergent care.
42	Charges exceed fee schedule or max allow amount.
44	Prompt-pay discount.
45	Charges exceed contracted/legislated fee arrangement.
49	Not routine exam or screening procedure.
50	Not deemed a `medical necessity' by the payer.
51	Pre-existing condition
52	Provider not eligible to refer/prescribe/order/perform the service billed.
53	Services by an immediate relative or household member.
54	Multiple physicians/assistants are not covered.
55	Experimental treatment.
56	Procedure has not `proven to be effective'.
57	Does not support this level of service.
58	Performed at inappropriate or invalid place of service.
59	Adjusted based on multiple surgery rules or concurrent anesthesia rules.
60	Outpatient services proximity to inpatient services not covered.
61	Failure to obtain second surgical opinion.
62	Charges differ than pre-certification/authorization.
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
78	Non-Covered days/Room charge adjustment.
85	Interest amount.
87	Transfer amount.
88	Adjustment to recover overpayment.
89	Professional fees removed from charges.
94	Processed in Excess of charges.
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure.
A0	Patient refund amount.
A1	Claim denied charges.

Code	Adjustment Reason Definition
A2	Contractual adjustment.
A6	Prior hospitalization or 30-day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B10	Amount reduced. Partial pay. Beneficiary not liable for more than the charge limit for the basic procedure/test.
B14	Payment denied. Only one visit or consultation per physician per day is covered.
B15	Payment adjusted. Procedure/service is not paid separately.
B17	Payment adjusted. Not prescribed, prior to delivery, is incomplete, or prescription not current.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B22	This payment is adjusted based on the diagnosis.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
B4	Late filing penalty.
B5	Payment adjusted. Coverage/program guidelines not met or were exceeded.
B6	Payment adjusted when performed/billed by this type of provider.
B7	Provider not eligible to be paid for procedure on this date of service.
B8	Service not covered/reduced because alternative services were available.
B9	Services not covered because the patient is enrolled in a Hospice.
W1	Workers Compensation State Fee Schedule Adjustment.