

TO: Physicians and Independent Clinics

SUBJECT: Billing Tips for Pediatric Services

PURPOSE: To give providers of pediatric services tips on how to avoid and/or correct common billing problems.

ACTION: BILLING TIPS

1. When completing any claim form, please make sure that all required fields are completed for each billing line of the claim form. This includes the date(s) of service, the place of service, the type of service, the procedure code, the diagnosis code, units, the charges, and, where appropriate, the individual servicing provider number. PLEASE NOTE: Charges for an office visit must indicate a unit in the appropriate field, e.g., one office visit equals one unit of service.
2. Many HCPCS codes, including those for EPSDT, pediatric HealthStart, initial and annual health maintenance examinations are age specific codes. Use of a code inappropriate for the child's age may result in "Error Code 254 -Procedure Code/Age Restriction".

If you receive a claim correction form for the "Error Code - 254", usually you can make the correction by simply indicating the correct code for the child's age. If the claim has been denied, resubmit the claim using the proper code. Please note that using the wrong Medicaid Identification Number (ID) on the claim may also cause the claim to be denied with this error because the age associated with that Medicaid Identification Number (ID) is different. If this situation occurs, make the correction by inserting the correct Medicaid Identification Number (ID).

3. The Report and Claim for EPSDT/HealthStart Screening and Related Procedures form (MC-19) should be used only for billing pediatric HealthStart (W9060 -W9068) or EPSDT (W9060 WT- W9068 WT, W9820) codes and other services provided on the same day as the EPSDT or pediatric HealthStart examination. HealthStart pediatric providers who are hospital outpatient departments should use the MC-19 only for billing the procedure code W9070.

The EPSDT or HealthStart examination procedure code should always appear on the first line of the claim. Do not use the MC-19 claim form when

billing routine office or annual health maintenance procedure codes. If the MC-19 is submitted inappropriately, it will result in a denial for "Error Code 247 - HCPCS Procedure Code on Claim Conflicts with Claim Type". The service may be paid by resubmitting the code on the proper form.

4. Please remember that the EPSDT, HealthStart and the annual health maintenance examination procedure codes are mutually exclusive. For example, if an annual EPSDT or HealthStart examination had been billed and paid for, a claim for an annual health maintenance examination performed within the following 12 months will be denied.

In completing the bottom portion of the MC-19, make sure that a value is entered for each section of the assessment results (indicated by the letters A through H), for each type of laboratory test, and for each type of immunization. Since all components of the examination must be completed, do not leave the vision, dental or hearing sections of the form blank because the child is an infant. The purpose of these sections is to record that an age appropriate assessment has been performed as part of this general examination. This does not imply that a formal standardized testing has been performed.

If you need assistance in completing the MC-19, please refer to the item-by-item instructions on page 6-13 of the Fiscal Agent Billing Supplement for physician or independent clinic services or contact the staff of Paramax/Unisys Provider Services at 1-800-776-6334.

5. If you encounter "Error Code 301 - Recipient Not Eligible on Date of Service", check to make sure that the client's Medicaid Identification Number (ID) has not changed for that date of service. This is not uncommon, especially following a move or the birth of the first child. In addition, check that the date on the claim form, or the dates as keyed by Paramax/Unisys are correct. For example, inadvertently using January 1991 date of service instead of January 1992 may result in an eligibility error.
6. Procedure codes HCPCS 90225 (CPT-4, 1991 Edition) or HCPCS 99431 (CPT-4, 1992 Edition) denote initial hospital care of a normal newborn. For purposes of the New Jersey Medicaid program, this procedure code, billed as one unit, covers the normal newborn's entire hospital stay. There is no additional reimbursement for HCPCS 90282 (CPT-4, 1991 Edition) or HCPCS 99433 (CPT-4, 1992 Edition) and if submitted for payment, claims using either of these procedure codes will be denied. Services to a sick newborn should be billed using the appropriate procedure codes in the Hospital Inpatient Services series of the CPT-4.
7. The incorrect use of HCPCS 90742 for acellular DTP or haemophilus influenza b has been recently identified as a billing error. The CPT-4 defines HCPCS 90742 as "Immunization, passive, specific hyperimmune serum globulin." The correct HCPCS for haemophilus influenza b immunization is HCPCS 90737. Immunization against diphtheria, tetanus and pertussis should be billed as HCPCS 90701 whether the regular or acellular DPT vaccine was used. The use of incorrect procedure codes will cause the claims to be denied.

8. If you encounter "Error Code 321 - Recipient Not on File", there is usually one of three causes:

- (1) An incorrect digit was entered on the claim form;
- (2) An incorrect person number (last 2 digits of the Medicaid
- (3) Data entry errors.

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Confirm the Medicaid Identification Number (ID) that was entered into the system by consulting the Remittance Advice Statement. If you find an incorrect Medicaid Identification Number (ID) was either placed on the claim form or data entered, please resubmit the claim with the correct number.

9. Remember that the date of birth is an important item when billing claims for children. When billing for a newborn who does not have an individual Medicaid Identification Number (ID), you may use the mother's number with the baby's date of birth. It is no longer necessary to indicate "Newborn Plus 60" on the claim form. The system uses the difference between the date of birth on the claim and the date of birth associated with the Medicaid Identification Number (ID) to identify a newborn claim.

If you receive "Error Code 311 - Correct Date of Birth or Resubmit Claim Under Baby's Number", one of the following has probably happened:

- (1) You are attempting to bill for a newborn under the mother's number for longer than the allowable period;
- (2) The date of birth that was entered into the system, either
- (3) The Medicaid Identification Number (ID) was incorrectly
- (4) The birth date supplied to Medicaid was incorrect.

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In the case of an incorrect date of birth or Medicaid Identification Number (ID), please indicate the correct date of birth on the claim correction form or on the resubmitted claim. If you are sure the date of birth and Medicaid Identification Number (ID) as entered are correct, please have the Medicaid recipient contact the county welfare agency to have the date of birth corrected in the Medicaid records. The New Jersey Medicaid program is working on the unique billing problem associated with multiple births. A separate directive will be issued to the providers concerning this problem.

If you have other questions or need additional assistance, please contact Paramax/Unisys, Provider Services Unit at 1-800-776-6334.

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(BLUE TAB MARKED "5").