Appendix S-1

Technical Guidelines for Paper Claim Preparation
Form HFS 2360, Health Insurance Claim Form

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the department:

- Use original department issued claim form. The department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the Health Center.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch/font size must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and practitioner signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold claims or fasten attachment with staples.

A sample of the HFS 2360 (pdf) may be found on the department's Web site. Instructions for completion of this claim follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for the form completion as follows:

Required = Entry always required.
Optional = Entry optional - In some cases failure to include an entry will result in certain assumptions by the department and will preclude corrections of certain claiming errors by the department.
Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required = Fields not applicable to the provision of Health Center services.

Completion	Item	Explanation and Instructions
Required	**1.**	**Patient's Name** – Enter the recipient's name exactly as it appears on the Identification Card or Notice. Use spaces to separate the components of the name (first, middle initial, last) in the proper order of the name field.
Optional	**2.**	**Patient's Date of Birth** – Enter the month, day and year of birth of the patient as shown on the Identification Card or Notice issued by the department. Use the MMDDYY format. If the birthdate is entered, the department will, where possible, correct claims suspended due to recipient name or number errors. If the birthdate is not entered, the department will not attempt corrections. Age – leave blank.
Not Required	3. – 7.	Leave blank.
Required	**8.**	**Medicaid Number** – Enter the nine-digit number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Not Required	9.	Other Health Insurance Coverage – Leave blank.
Conditionally Required	**10.**	**Was Condition Related to** – If the patient sought treatment for an injury or illness that resulted from employment, type a capital "X" in the Yes box under A, Patient's Employment. If the patient sought treatment for an injury or a condition that resulted from an automobile accident, type a capital "X" in Field 10B, AUTO. If the place of service billed is for Emergency Department Services, type a capital "X" in Field 10B, OTHER.
Not Required	11.	Insured's Address – Leave blank.

Completion	Item	Explanation and Instructions
Required	**12.**	**Recipient's or Authorized Person's Signature** – The recipient or authorized representative must sign and enter a date unless the signature is on file with the practitioner/supplier. **If the signature is on file, enter the statement "Signature on File" here**.
Not Required	13.	Leave blank.
Conditionally Required	**14.**	**For prenatal services, enter the date of the Last Menstrual Period (LMP).** Use MMDDYY format.
Not Required	15.	Leave blank.
Conditionally Required	**16.**	**Check here if emergency.**
Not Required	17–18	Leave blank.
Conditionally Required	**19.**	**Name of Referring Practitioner or Other Source** – This field is required when charges are being submitted for a **consultation**. Additionally, a referring practitioner's name is always required when a referring practitioner NPI is entered. **Referring Practitioner Number** – The referring practitioner number is always required when a referring practitioner name is entered. Enter the referring practitioner's NPI.
Not Required	20.	Leave blank
Conditionally Required	**21.**	**Facility Where Services Rendered** – This entry is required when Place of Service Code in Field 24B is other than 11 (office) or 12 (home). Address may be abbreviated.
Not Required	22.	Leave blank.
Conditionally Required	**23a.**	**Healthy Kids Services** – If services rendered were Healthy Kids services, enter a capital X in the Yes box.
Conditionally Required	**23b.**	**Family Planning** – If services were rendered for family planning purposes, enter a capital X in the Yes box.
Not Required	**23c.**	Leave blank.
Not Required	**23d.**	Leave blank.
Required	**23e.**	**T.O.S. (Type of Service)** – Enter the code corresponding to the type of service for which the charges submitted on the claim apply. Only one type of service can be included on a single claim. A separate claim must be prepared for each type of service for which charges are made. Only the following codes are allowable for SBLHC: 1 – Medical Care 2 – Surgery

Completion	Item	Explanation and Instructions
Optional	**23f.**	**Diagnosis or Nature of Injury or Illness** – Enter the diagnosis or nature of injury or illness description that describes the condition primarily responsible for the patient's treatment. A written description is not required if a valid ICD-9-CM, or upon implementation, ICD-10-CM, Code is entered in Item 24D.
Optional	**24.**	**Repeat** – Usage not recommended.
Required	**24a.**	**Date of Service** – Enter the date the service was rendered. Use MMDDYY format.
Required	**24b.**	**Place of Service** – Enter the appropriate 2-digit code which identifies the place where the service was provided: 03 - School
Required	**24c.**	**Procedure Code/Drug Item No.** – Enter the appropriate procedure code or NDC. Refer to Appendix S-3 for information regarding NDC billing.
Conditionally Required	**24c.**	**MOD** – Enter the appropriate two-character modifier for the service performed. A listing of the modifiers recognized in processing HFS claims may be found on the modifier listing for practitioner claims.
Required	**24d.**	**Primary Diagnosis Code** – Enter the specific ICD-9-CM, or upon implementation, ICD-10-CM, Code without punctuation or spaces for the primary diagnosis.
Optional	**24d.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered. Enter only a specific ICD-9-CM, or upon implementation, ICD-10-CM. Code without punctuation or spaces.
Required	**24e.**	**Charges** – Enter the total charge, in both dollars and cents, for the service. Do not deduct any Third Party Liability payments or copayments from these charges.
Required	**24f.**	**Days/Units** – Unless otherwise stated or allowed, enter a quantity of '1'. A four-digit entry other than '1' is required when billing for multiples; refer to the [fee schedule key].
Optional		**Delete** – When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.

Completion	Item	Explanation and Instructions
Required	**25.**	**Signature of Physician and Date Signed** – After reading the certification statement printed on the back of the claim form, the practitioner or authorized biller (practitioner's name followed by biller's initials) must sign the completed form. **The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable.** Unsigned claims will not be accepted by the department and will be returned to the practitioner when possible. The date of the practitioner's signature is to be entered in the MMDDYY. The signature should not enter the date section of this field.
Required	**26.**	**Accept Assignment** – The practitioner must accept assignment of Medicare benefits for services provided to participants. Enter a capital "X" in the "Yes" box.
Required	**27.**	**Total Charges** – Enter the sum of all charges submitted on the claim in service section 1 through 7. Do not include charges for any deleted sections.
Required	**28.**	**Amount Paid** – Enter the sum of all payments received from other sources. The entry must equal the sum of the amounts as shown in fields 37C and 38C, TPL Amount. If no payment was received enter three zeroes (000). Do not collect primary copayments on Medicaid secondary claims. Do not include HFS copayments or amount previously paid by the department as primary payment.
Required	**29.**	**Balance Due** – Enter the difference between Total Charges and Amount Paid.
Required	**30.**	**Your Provider Number** – Enter the site-specific health center NPI.
Required	**31.**	**Provider Name, Address, ZIP Code** – Enter the health center's name exactly as it appears on the Provider Information Sheet. Enter the street address of the health center. If an address is entered, the department will, where possible, correct claims suspended due to provider eligibility errors. If an address is not entered, the department will not attempt to make corrections. Enter city, state and zip code of health center.
Optional	**32.**	**Your Patient's Account Number** – Enter up to 20 numbers or letters used in your accounting system for identification. If this field is completed, the same data will be reported on the HFS 194-M-2, Remittance Advice.
Required	**33.**	**Your Payee Code** – Enter the one-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Required	**34.**	**Number of Sections** – Enter the number of service lines correctly completed above in Section 24. Do not include **deleted** sections.

Completion	Item	Explanation and Instructions
Not Required	35. - 36.	Leave blank.
Conditionally Required	**37a.**	**TPL Code** – If the patient's Identification Card contains a TPL Code, the numeric three-digit code must be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in the Chapter 100, General Appendix 9. If the participant has more than one third party resource, the additional TPL is to be shown in 38A. – 38D. **Do not attach a copy of the TPL Explanation of Benefits (EOB).** Practitioners providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a patient's private insurance carrier prior to billing the department for these services. **Do not report Medicare Information in the TPL fields.** For Medicare denied services with an additional TPL resource involved, please report the following: • Do not report the Medicare information in the TPL field. • Do attach a copy of the Medicare EOB. • Enter other TPL information in the TPL fields. • Do not attach a copy of the other TPL EOB. **Spenddown** – Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a recipient liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual recipient liability as shown on the HFS 2432 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a recipient liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Explanation and Instructions
Conditionally Required (Continued)	37a	HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a recipient liability of greater than $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 01 TPL Amount the actual recipient liability up to total charges TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 01 if remaining liability from claim 1 is greater than $0.00 or 04 if remaining recipient liability from claim 1 is $0.00. TPL Amount If status code 01 was used in claim 2 status field, enter amount of remaining recipient liability after claim 1. If status code 04 was used in claim 2 status field, enter 000. TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a recipient liability of $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions.

Completion	Item	Explanation and Instructions
Conditionally Required	**37b.**	**TPL Status** – If a TPL Code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL Code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the Health Center is advised **by the third party resource** that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the Health Center is advised **by the third party resource** that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the Health Center that the third party resource identified on the Identification Card is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the Health Center determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed.
		10 – Deductible not met: TPL Status Code 10 is to be entered when the Health Center has been informed **by the third party resource** that non-payment of the service was because the deductible was not met.
Conditionally Required	**37c.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

<table>
<tr><th>Completion</th><th>Item</th><th>Explanation and Instructions</th></tr>
<tr><td>Conditionally Required</td><td>37d.</td><td>TPL Date – A TPL date is required when any status code is shown in field 37B. Use the date specified below for the applicable TPL Status Code:
Code Date to be entered
01 Third Party Adjudication Date
02 Third Party Adjudication Date
03 Third Party Adjudication Date
04 Date from the HFS 2432, Split Bill Transmittal
05 Date of Service
06 Date of Service
07 Date of Service
10 Third Party Adjudication Date</td></tr>
<tr><td>Conditionally Required</td><td>38a.
38b.
38c.
38d.</td><td>TPL Code – See 37A above
TPL Status – See 37B above
TPL Amount – See 37C above
TPL Date – See 37D above</td></tr>
</table>

Mailing Instructions

The Health Insurance Claim Form is a single page or two-part form. The Health Center is to submit the original form to the department as indicated below. The pin-feed guide strip of the two-part form should be removed prior to submission to the department. The Health Center should retain a copy of the claim.

Routine claims are to be mailed to the department in pre-addressed mailing envelopes, HFS 1444, Provider Invoice Envelope, provided by the department.

Mailing address: Illinois Department of Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as Medicare denial EOMB or HFS 2432, Split Billing Transmittal submitted with a one page claim) are to be mailed to the department in pre-addressed mailing envelope, HFS 1414, Special Approval Envelope, which is provided by the department for this purpose.

Mailing address: Illinois Department of Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

Non-routine claims, HFS 2432, Split Billing Transmittal submitted with multiple claims are to be mailed to the department for special handling.

Mailing address: Illinois Department of Healthcare and Family Services
P.O. Box 19115
Springfield, Illinois 62794-9115

Forms Requisition - Billing forms may be requested on our Web site or by submitting a HFS 1517 as explained in Chapter 100.

Appendix S-2

Internet Quick Reference Guide

The department's handbooks are designed for use via the Web and contain hyperlinks to the pertinent information. This appendix was developed to provide a reference guide for providers who print the department's handbooks and prefer to work from a paper copy.

Internet Site	Web Address
Healthcare and Family Services website	http://www.illinois.gov/hfs/Pages/default.aspx
Administrative Rules	http://www.ilga.gov/commission/jcar/admincode/titles.html
All Kids Program	http://www.allkids.com/
Care Coordination	http://www.illinois.gov/hfs/MedicalProviders/cc/Pages/default.aspx
Claims Processing System Issues	http://www.illinois.gov/hfs/MedicalProviders/SystemIssues/Pages/default.aspx
Child Support Enforcement	http://www.childsupportillinois.com/
FamilyCare	http://www.familycareillinois.com/
Family Community Resource Centers	http://www.dhs.state.il.us/
Health Benefits for Workers with Disabilities	http://www.hbwdillinois.com/
Health Information Exchange	http://www.illinois.gov/sites/ilhie/Pages/default.aspx
Home and Community Based Waiver Services	http://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx
Illinois Health Connect	http://www.illinoishealthconnect.com/
Illinois Veterans Care	http://www.illinoisveteranscare.com/
Illinois Warrior Assistance Program	http://www.illinoiswarrior.com/
Maternal and Child Health Promotion	http://www.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/default.aspx
Medical Electronic Data Interchange (MEDI)	http://www.myhfs.illinois.gov/
State Chronic Renal Disease Program	http://www.illinois.gov/hfs/MedicalClients/renal/Pages/default.aspx
Medical Forms Requests	http://www.illinois.gov/hfs/MedicalProviders/Forms%20Request/Pages/default.aspx
Medical Programs Forms	http://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx
National Uniform Billing Committee (NUBC)	http://www.nubc.org/
Non-Institutional Provider Resources	http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx
Pharmacy Information	http://www.illinois.gov/hfs/MedicalProviders/pharmacy/Pages/default.aspx
Provider Enrollment Information	http://www.illinois.gov/hfs/impact/Pages/ProviderEnrollment.aspx
Provider Fee Schedules	http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx
Provider Handbooks	http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx
Provider Releases	http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx
Registration for E-mail Notification	http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/ProviderEmailSubscribe.aspx
Place of Service Codes	**http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html**
Centers for Medicare and Medicaid Services (CMS)	**https://www.cms.gov/**

Appendix S-3

NDC Billing Instructions

The Health Insurance Portability and Accountability Act (HIPAA) standard code set for NDCs is eleven digits. The first segment must include five digits, the second segment must include four digits, and the third segment must include two digits (5-4-2 configuration). For example, 12345-1234-12 is a correctly configured NDC. However, the NDC on the product label might not contain 11 digits. The labeler may have dropped leading zeros in a segment. In this situation, the appropriate number of leading zeros must be added at the beginning of each segment to ensure that the NDC is shown in the 5-4-2 format. Where the zero is added depends upon the configuration of the NDC.

The following table provides examples of incorrectly configured NDCs and the corresponding correctly configured NDC. The segment that is missing the leading zero is bolded in each example.

NDC on Label	Configuration on Label	NDC in Required 5-4-2 Format
05678-**123**-01	5-3-2	05678-0123-01
5678-0123-01	4-4-2	05678-0123-01
05678-0123-**1**	5-4-1	05678-0123-01

The following provides NDC billing instructions.

HIPAA 837P Transactions and Direct Data Entry through the MEDI System
For HIPAA 837P electronic claim transactions, the HCPCS Code is reported in Loop ID 2400 and the NDC is reported in Loop ID 2410. For more detailed information please refer to the billing instructions for electronic claim transactions found in Chapter 300, Topic 302.

Providers registered to bill through the Direct Data Entry MEDI System can access instructions for the specific claim format HFS 2360 (pdf), HFS 1443 (pdf).

Paper Transactions
The HCPCS Code with the charge and the appropriate quantity based on the HCPCS definition should be billed on one service line on the HFS 2360 (pdf). The corresponding NDC must always be reported on the service line directly after the drug HCPCS Code service line. The NDC service line(s) must include the date of service, place of service, NDC Code without dashes, and NDC charge amount of zero. On the HFS 3797 (pdf), the corresponding NDC must be reported in Section 11.

Reporting Quantities
These instructions apply to both paper claims and electronic transactions.

At this time, the department will use only the HCPCS quantities/units for payment and rebate purposes.

When a provider uses more than one NDC of a drug, the provider must include all NDCs on the claim. The quantity for **each** NDC must be reported separately by repeating the HCPCS Code. Please refer to the **Reporting of Multiple NDCs** section.

Reporting Charges
These instructions apply to both paper claims and electronic transactions.

The provider's charge must be reported for each HCPCS Code. A charge of zero should be reported for each NDC.

Reporting of Multiple NDCs
These instructions apply to both paper claims and electronic transactions.

At times, it may be necessary for providers to bill multiple NDCs for a single procedure code. This may happen when two different strengths of the same drug are needed in order to administer the appropriate dose. This will also be necessary when multiple vials of the same drug are used to administer the appropriate dose, and different manufacturers manufacture the vials. Modifiers 76 and 51 are to be submitted as necessary.

Billing examples of these situations are provided below. The examples apply to both paper claims and electronic transactions.

Procedure for billing one HCPCS and multiple NDCs:

Service Line 1 or Loop 2400:	HCPCS Code
	Report HCPCS quantity associated with NDC in Service Line 2
Service Line 2 or Loop 2410:	NDC associated with Service Line 1
Service Line 3 or Loop 2400:	HCPCS Code (same as Service Line 1) - Modifier 76 (Repeat Procedure)
	Report HCPCS quantity associated with NDC in Service Line 4
Service Line 4 or Loop 2410:	NDC associated with Service Line 3
Service Line 5 or Loop 2400: (Multiple Procedures)	HCPCS Code (same as Service Line 1 & 3) - Modifier 51
	Report HCPCS quantity associated with NDC in Service Line 6
Service Line 6 or Loop 2410:	NDC associated with Service Line 5

Example 1: Procedure for billing **three (3)** 250 mg vials of ceftriaxone manufactured by two different manufacturers.

Provider will bill **a total quantity of** three (3) HCPCS procedure code units, but will divide those units, as follows:

Service Line 1 or Loop 2400:	J0696 billed with a quantity of 2
Service Line 2 or Loop 2410:	00781320695
Service Line 3 or Loop 2400:	J0696 and modifier 76 billed with a quantity of 1
Service Line 4 or Loop 2410:	00409733701

Reporting Multiple NDCs – Example 1

HCPCS Code	Modifier	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0696		Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	Two (2) 250 mg vials	2	00781320695 ceftriaxone 250 mg vial manufactured by Sandoz
J0696	76	Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	One (1) 250 mg vials	1	00409733701 ceftriaxone 250 mg vial manufactured by Hospira

Example 2: Procedure for billing 125 mcg of Aranesp (darbepoetin alfa) using two different vials/strengths of the drug: one (1) 25 mcg syringe and one (1) 100 mcg syringe.

Provider will bill **a total quantity of** 125 HCPCS procedure code units, but will divide those units, as follows:

Service Line 1 or Loop 2400: J0881 billed with a quantity of 25
Service Line 2 or Loop 2410: 55513005704
Service Line 3 or Loop 2400: J0881 with modifier 76 billed with a quantity of 100
Service Line 4 or Loop 2410: 55513002504

Reporting Multiple NDCs - Example 2

HCPCS Code	Modifier	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0881		Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 25 mcg/ 0.42 ml syringe	25	55513005704 Aranesp 25 mcg/0.42 ml syringe
J0881	76	Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 100 mcg/ 0.5 ml syringe	100	55513002504 Aranesp 100 mcg/0.5 ml syringe

Hand Priced Drug Procedure Codes

These instructions apply to both paper claims and electronic transactions.
Providers must report both the HCPCS Code and NDC for drugs requiring hand pricing. These procedure codes are identified on the Practitioner Fee Schedule. Providers must report the HCPCS Code in the procedure field, and the product name, strength and the dosage administered or dispensed in the description field. The description field is Box 24C on the paper HFS 2360 claim, the “procedure literal description” field for DDE claims, or the NTE segment of Loop 2400 for electronic transactions. On paper claims only, the quantity in the units field must be 1. In the service line immediately following, providers must report the NDC as the procedure code and charge amount as “0.”

Appendix S-4
Vaccinations Billing Instructions

Children 0 through 18 years of age

Example #1 A well-child examination is performed, and routine vaccinations are administered at the same time. The well-child examination is submitted using the appropriate CPT Code for the preventive medicine visit. Vaccinations are billed using the appropriate CPT Codes for the specific vaccines. The department reimburses for the visit at the fee schedule rate, for the VFC vaccine administrative services at $6.40, and for the non-VFC vaccine at the fee schedule rate.

HCPCS	Description	Reimbursement rate
99xxx	evaluation and management code	Per fee schedule
90xxx	specific VFC-provided vaccine	$6.40
90xxx	non-VFC vaccine cost	Per fee schedule

Example #2 A child presents solely to receive a vaccine available through VFC. The salaried staff member administers the vaccine. The office visit is submitted using the CPT Code for a minimal level office or other outpatient visit for evaluation and management not requiring the presence of a physician. The vaccination is billed using the appropriate CPT Code for the specific vaccine. The department reimburses for the visit at the fee schedule rate and for the VFC vaccine administrative services at $6.40.

HCPCS	Description	Reimbursement rate
99211	evaluation and management code	Per fee schedule
90xxx	specific VFC-provided vaccine	$6.40

Adults 19 years of age or older

Example #3 An office visit for an adult is performed for reasons other than receiving an immunization. A vaccine is then recommended and administered. The office visit is submitted using the CPT Code for the appropriate level office or other outpatient visit for evaluation and management. The vaccination is billed using the appropriate CPT Code for the specific vaccine. The department reimburses for the visit at the fee schedule rate and for the cost of the vaccine at the fee schedule rate.

HCPCS	Description	Reimbursement rate
99xxx	evaluation and management code	Per fee schedule
90xxx	vaccine cost	Per fee schedule

Example #4 An adult presents solely to receive a vaccine. The salaried staff member administers the vaccine. The office visit is submitted using the CPT Code for the minimal level office or other outpatient visit for evaluation and management not requiring the presence of a physician. The vaccination is billed using the appropriate CPT Code for the specific vaccine. The department reimburses for the visit at the fee schedule rate and for the cost of the vaccine at the fee schedule rate.

HCPCS	Description	Reimbursement rate
99211	evaluation and management code	Per fee schedule
90xxx	vaccine cost	Per fee schedule

Appendix S-5

Julian Date Calendar (Perpetual)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

Appendix S-5

Julian Date Calendar (Leap Years)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31