



NETWORK Notification

Notice Date: August 29, 2022
To: CareSource PASSE Providers
From: CareSource PASSE
Subject: Including Taxonomy and Medicaid ID on Claims

Summary

The Arkansas Department of Human Services (DHS) requires CareSource PASSE™ to submit timely, complete and accurate encounters data to:

- I. Determine the financial accuracy of payments made to providers
- II. Evaluate PASSE compliance to Service Level Agreements
- III. Evaluate overall PASSE program

To meet above requirements/Service Level agreements, DHS requires certain data elements to be present on encounters submissions. These data elements, such as National Provider Identifier (NPI) and physical billing address, taxonomy code or Arkansas Medicaid ID, help DHS to match the provider receiving payments to the provider’s active registration with the Arkansas Medicaid program.

Impact

To better assist CareSource in making sure that claims are matched correctly to the provider’s active registration with Medicaid, we are requesting the providers submit additional information on claims:

Typical Provider Validation	Atypical Provider Validation
<ul style="list-style-type: none"> • NPI 	<ul style="list-style-type: none"> • Medicaid ID
<ul style="list-style-type: none"> • Physical Billing Address (zip 5+4) 	<ul style="list-style-type: none"> • Physical Billing Address (zip 5+4)
<ul style="list-style-type: none"> • Arkansas Medicaid ID or Taxonomy 	

Please refer examples and attached guidelines document for proper method of submitting Billing Provider Medicaid ID on Claim forms UB04 & HCFA1500 and electronic format (EDI) X12 837 Inst & Prof file types.

Guidelines examples for properly reporting Billing Provider Information

The below scenario assumes providers submit claims according to how the provider registered with Arkansas Medicaid, including an active Arkansas Medicaid ID, registered taxonomy, NPI (if any) and full physical billing address as on file with Arkansas Medicaid.

Examples:

Provider registered with the same NPI, taxonomy, and physical address for multiple provider types. Provider must add the applicable Medicaid ID on all claim submissions in the below scenario.

Billing Medicaid ID	Billing NPI	Billing Taxonomy	Billing Physical Address	Billing Zip 5+4	Provider Type
123456724	1234567890	261QR0400X	1234 Any Ave	111114444	24 - ADDT
234567842	1234567890	261QR0400X	1234 Any Ave	111114444	42- Therapy Group
345678990	1234567890	261QR0400X	1234 Any Ave	111114444	90 - Children's Services/Respite

Below, we've listed guidelines for properly reporting Billing Provider information on UB04 – Hospital Claims:

UB04 form

UB04 form	
Locator	Field Description
1	Billing Address with Zip 5 + 4
56	Billing NPI
57a	Other Provider ID (Medicaid ID)
57b	Billing Provider Taxonomy

UB04 Form

Any Hospital 123 Any Street Dayton OH 111114444		Any Hospital 456 Any Street Dayton OH 11111		1234 12345	0111
Patient ID if different from sub		1234 ABC street		Country code if other than USA	
Patient Name: Dayton		Condition codes using the two-digit codes from the NUBC manual for up to 11 occurrences		OH 11111	
Occurrence codes and dates using the NUBC manual for codes		Occurrence span codes and dates in MMDDYY format		Not in Use	
John Doe 1234 ABC Street Dayton, OH 11111		Value codes and amounts for special circumstances from the NUBC manual			
0129 Semi-Private 0250 Pharmacy 0360 OR Services	200.00 5000 10000	2 1	20000 5000 10000	000 000 000	Future Use
RED = Required Black = Situational/Required, if applicable/Optional					
Please see the Red Highlighted Boxes: <ul style="list-style-type: none"> Billing NPI should be reported in Box 56. Billing Provider Medicaid ID/Secondary Identification should be reported in Box 57a with correct Qualifier. Billing Provider Taxonomy goes in the Box 57b with the correct Qualifier. Billing Physical address with Zip5 + 4 should be reported in Box 1. 					
PAGE 1 OF 1		CREATION DATE		TOTALS	35000 000
Payer 123 Secondary Payer Tertiary Payer		Report HIPAA National Health Plan Identifier when mandatory.		Estimated Amount due	3333333333 1234567890 XXXXXXXXXXXX
Doe, John Secondary Tertiary		18	123456780012	ABC, INC.,	1234
ATTENDING PHYSICIAN Williams Paul		1234567891			

Electronic Data:

Electronic Data			
Loops	Segment	Qualifier	Description
2010AA- Billing Provider Name	NM1/85/09	NM108 = XX	Billing Provider Identifier – National Provider Identifier
2010AA- Billing Provider Name	N301, N302		N301 – Address Information N302 – Address Information
2010AA- Billing Provider Name	N401 N402 N403		N401 - BILLING PROVIDER CITY, N402 – STATE N403 - ZIP CODE
2000A - Billing Provider specialty information	PRV/BI/PXC	PRV03 = PXC	PRV03 – Provider Taxonomy Code

2010BB - Payer Name	REF01	G2	Qualifier
	REF02		Billing Provider Secondary Identification

Example: EDI 837 Format

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ISA*00*          *00*          *ZZ*2222          *ZZ*311143211          *220725*2258*|*00501*22222222*0*P*:
GS*HC*ABC*311143211*20220722*225834*11111111*X*005010X223A2
ST*837*000000002*005010X223A2
BHT*0019*00*05678      22203002215ABC*20220725*2136*CH
NM1*41*2*ZZZZZ INC*****46*05678
PER*IC*ABC EDI DEPARTMENT*TE*8888001234
NM1*40*2*ABCDEF*****46*12345
HL*1**20*1
PRV*BI*PXC*XXXXXXXXXX          Billing Taxonomy
NM1*85*2*AAA Provider*****XX*111111111          Billing Provider NPI
N3*111 ABC Road          Billing Provider Physical Address
N4*DAYTON*OH*111114444
REF*EI*123456789          Billing Zip 5 + 4
PER*IC*AAA Provider*TE*8888008888
HL*2*1*22*0
SBR*U*18*****MC
NM1*IL*1*DOE*JOHN****MI*123456789
N3*123 Main Street
N4*Dayton*OH*454581234
DMG*D8*19960422*M
NM1*PR*2*abcdef*****PI*05678
N3*123 ABC street
N4*COLUMBUS*OH*11111          Billing Provider Medicaid ID
REF*G2*123456789
CLM*123456*27600***11:A;1**A*Y*Y
DTP*096*TM*1051
DTP*434*RD8*20220622-20220706
DTP*435*DT*202206221932
CL1*1*4*01
REF*EA*000033333
REF*D9*4444444444444
HI*ABK:F259:Y
HI*ABJ:F259
HI*DR:885
HI*ABF:R45851:Y*ABF:J45909:Y*ABF:F4310:Y*ABF:F17211:Y*ABF:R456:Y*ABF:R112:Y*ABF:R197:Y*ABF:Z8659*ABF:Z5900*ABF:Z91120
HI*BE:80:16
NM1*71*1*Wilson*ABC***XX*111111111
PRV*AT*PXC*XXXXXXXXXX
SBR*P*18**MEDICARE*****MA

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Guidelines for properly reporting Billing Provider information on HCFA-1500 (Professional) Claims:

HCFA 1500 form

CMS 1500 Item #	Description
33	Billing Physical address with Zip 5 + 4
33a	Billing Provider NPI
33b	Billing Provider Legacy Number or PIN with G2 Qualifier
33c	Billing Provider Taxonomy with ZZ Qualifier

HCFA 1500

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SON or ID) (SSN) (ID)	1a. INSURED'S ID NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John	3. PATIENT'S BIRTH DATE SEX 05 05 05 M <input checked="" type="checkbox"/> <input type="checkbox"/>
5. PATIENT'S ADDRESS (No. Street) 123 Main Street	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John
6. CITY STATE Dayton OH	7. INSURED'S ADDRESS (No. Street) 123 Main Street
7. ZIP CODE TELEPHONE (Include Area Code) 12345 ()	8. CITY STATE Dayton OH
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	9. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>
9. OTHER INSURED'S POLICY OR GROUP NUMBER	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
10. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	11. INSURED'S POLICY GROUP OR FECA NUMBER
11. EMPLOYER'S NAME OR SCHOOL NAME	12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>
12. INSURANCE PLAN NAME OR PROGRAM NAME	13. EMPLOYER'S NAME OR SCHOOL NAME
13. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	14. INSURANCE PLAN NAME OR PROGRAM NAME
14. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Patient Signature Date	16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED
16. DATE OF CURRENT ILLNESS (First symptoms OR INJURY (Accident OR PRECIPITANCY/ONSET) MM DD YY	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Jane A Smith
17. G2 ABC1234567890 17b. NPI 0123456789	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 1. R6250 3. ICD Ind ABK	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE (ENCL) C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIERS E. DIAGNOSIS POINTER F. \$ CHARGES G. DATE OF PAYMENT H. ICD-9-CM Code I. ICD-10-CM Code J. RENDERING PROVIDER'S ID #	23. PRIOR AUTHORIZATION NUMBER
05 05 08 05 05 08 49 T1234 U6 UB A 100.00 4	G2 234567891 2345678900
<p>Please see the Red Highlighted Boxes:</p> <ul style="list-style-type: none"> Billing NPI should be reported in Box 33a Billing Provider Medicaid ID/Secondary Identification should be reported in Box 33b with G2 Qualifier. Billing Provider Taxonomy should be reported in Box 33b with ZZ Qualifier. Billing Physical address with Zip5 + 4 should be reported in Box 33. 	<p>RED = Required Black = Situational/Required, if applicable/Optional</p>
25. FEDERAL TAX ID NUMBER SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/> 123456789	26. PATIENT'S ACCOUNT NO. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 12341234
27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 100.00
31. SERVICE FACILITY LOCATION INFORMATION General Hospital 1234 Hospital Street Anytown Dayton 111114444	32. BILLING PROVIDER INFO & PH # AAA Provider 111 ABC Road Dayton OH 111114444
33. SIGNATURE DATE	34. BILLING PROVIDER INFO & PH # 1111111111111111 G2567890123

Electronic Data:

Electronic Data			
Loops	Segment	Qualifier	Description
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2010AA- Billing Provider Name	N301, N302		N301 – Address Information N302 – Address Information
2010AA- Billing Provider Name	N401 N402 N403		N401 - BILLING PROVIDER CITY, N402 – STATE N403 - ZIP CODE
2000A - Billing Provider specialty information	PRV03	PRV03 = PXC	PRV03 – Provider Taxonomy Code

2010BB - Payer Name	REF01	G2	Qualifier
	REF02		Billing Provider Secondary Identification

Example: EDI 837 Format

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ISA*00*          *00*          *01*222222222      *ZZ*311143265      *220723*0030*^*00501*22222222*0*P*:
GS*HC*222222222*311143265*20220127*0030*111111111*X*005010X222A1
ST*837*1005*005010X222A1
BHT*0019*00*40933614169*20220127*0030*CH
NM1*41*2*ZZZZZ  INC*****46*H1234
PER*IC*EDI  OPERATIONS*TE*800888888*EX*7*EM*PRODUCTION@ZZZZZ.COM
NM1*40*2*ABCDEF*****46*311143265
HL*1**20*1
PRV*BI*PXC*XXXXXXXXXX
NM1*85*2*AAA  Provider*****XX*111111111
N3*111  ABC Raod
N4*DAYTON*OH*111114444
REF*EI*123456789
PER*IC*AAA  Provider*TE*8001234567
HL*2*1*22*0
SBR*P*18*****CI
NM1*IL*1*DOE*JOHN****MI*12345678911
N3*123  Main Street
N4*Dayton*OH*454581234
DMG*D8*20050505*M
NM1*PR*2*abcdef*****PI*ABCD
REF*G2*567890123
CLM*123456*100***02:B:1*Y*A*Y*I*P
REF*D9*444444444444
REF*EA*A-B-1234
NTE*ADD*1111
HI*ABK:F3181
NM1*82*1*ABC*DEF*****XX*111111111
PRV*PE*PXC*111111111
REF*G2*888888888
LX*1
SV1*HC:90837:U4*100*UN*1***1
DTP*472*D8*20220721
REF*6R*123456
SE*33*1005
GE*1*111111111
IEA*1*222222222

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Billing Taxonomy → PRV*BI*PXC*XXXXXXXXXX

Billing Provider NPI → NM1*85*2*AAA Provider*****XX*111111111

Billing Provider Physical Address → N3*111 ABC Raod, N4*DAYTON*OH*111114444

Billing Zip 5 + 4 → REF*EI*123456789

Billing Provider Medicaid ID → REF*G2*567890123

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