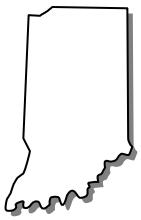


P R O V I D E R B U L L E T I N

B T 2 0 0 5 1 4 J U N E 3 , 2 0 0 5

To: MRT Providers

Subject: Medical Review Team

Overview

The purpose of this bulletin is to provide information about the automation of the Medical Review Team (MRT) claims processing.

The role of the MRT is to determine an applicant's categorical eligibility for Medicaid under the disability category. The MRT consists of physicians and consultants who specialize in Medicaid eligibility disability determinations. These professionals review information to determine whether new applicants meet the criteria for disability, and establish medical reviews for current Medicaid members. The MRT issues favorable or unfavorable eligibility decisions based on medical evidence that supports whether the applicant has a significant impairment.

When a medical provider completes an assessment of an applicant and submits the required determination forms to the Division of Family Resources, the provider may submit a claim to EDS for payment of certain examinations and reports. If the MRT authorizes an applicant to obtain additional tests, a provider may also submit claims for these services. These services should not be performed unless the applicant presents the additional information request form. The provider should submit these claims for the member using the MRT member identification that begins with **850** and the member's social security number. If an applicant does not have or refuses to provide a Social Security Number, providers may contact the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 to obtain an MRT member identification number.

The State will continue to process paper MRT claims if they are postmarked no later than June 10, 2005. Providers should submit MRT claims postmarked no later than June 10, 2005, to the Office of Medicaid Policy and Planning (OMPP), c/o Stan Wilson, MS07, 402 W. Washington Street, Room W382, Indianapolis, IN 46204. If the OMPP receives claims postmarked after June 10, 2005, the OMPP will return the claims to the provider and ask the provider to resubmit the claims to EDS. Paper claims postmarked after June 10, 2005, must be sent to EDS using the paper CMS-1500 claim form. Do not attempt to bill electronically prior to July 1.

Effective July 1, 2005, MRT claims processing will be automated and merged with the existing IHCP claims processing technology. Providers should submit MRT claims to EDS using the paper CMS-1500 claim form, the electronic 837 Professional Claims and Encounters (837P) Transaction format, or Web interChange.

> *Note: Effective July 1, 2005, all claims must be submitted in a HIPAA-compliant claim format. EDS will not process the old MRT Claim Voucher that was used to submit claims to the OMPP.*

Providers can obtain information about how to submit claims using Web interChange and how to submit claims using the electronic 837P transaction by visiting http://www.indianamedicaid.com. This Web site includes Web interChange instructions, Companion Guides for Electronic Data Interchange (EDI) Solutions Transmissions, the current *Indiana Health Coverage Programs (IHCP) Provider Manual*, a provider field representative telephone listing, and additional IHCP information. For answers to specific questions, providers may also call the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis area or 1-800-577-1278.

Providers can submit specific questions about MRT claims processing in writing to the EDS Provider Written Correspondence Unit. Providers are encouraged to submit questions by obtaining, completing, and mailing the *Indiana Medicaid Inquiry Form* to the following address:

EDS Provider Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

Incomplete inquiries may be returned for additional information. Providers should allow ten business days to receive a response to their inquiries. The *Indiana Medicaid Inquiry* form is available online from the http://www.indianamedicaid.com Web site or by sending a request in writing to the following address:

EDS Forms Request
P.O. Box 7263
Indianapolis, IN 46207-7263

Provider Enrollment

Providers that submit claims for MRT and are currently enrolled as IHCP providers do not need to re-enroll. A provider's current IHCP provider identification (ID) number will be the provider's MRT provider ID. Providers must use an IHCP billing provider ID as they do for other IHCP claims. Providers that do not have an IHCP billing and/or rendering provider number, will need to obtain one or both to submit MRT claims, or to submit other IHCP claims.

To enroll as an MRT provider and to obtain a valid provider ID to submit claims, providers should visit the IHCP Web site at http://www.indianamedicaid.com, and complete an IHCP Enrollment Application. Providers must submit completed forms to the following address:

EDS Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

Member Eligibility

The County Office, Division of Family Resources is responsible for determining initial and continuing eligibility for Medicaid disability. To meet the disability requirement, a person must have a significant impairment that is expected to last a minimum of 12 months. The MRT makes this determination. The MRT notifies the County Office, Division of Family Resources with its decision.

Role of County Office and MRT

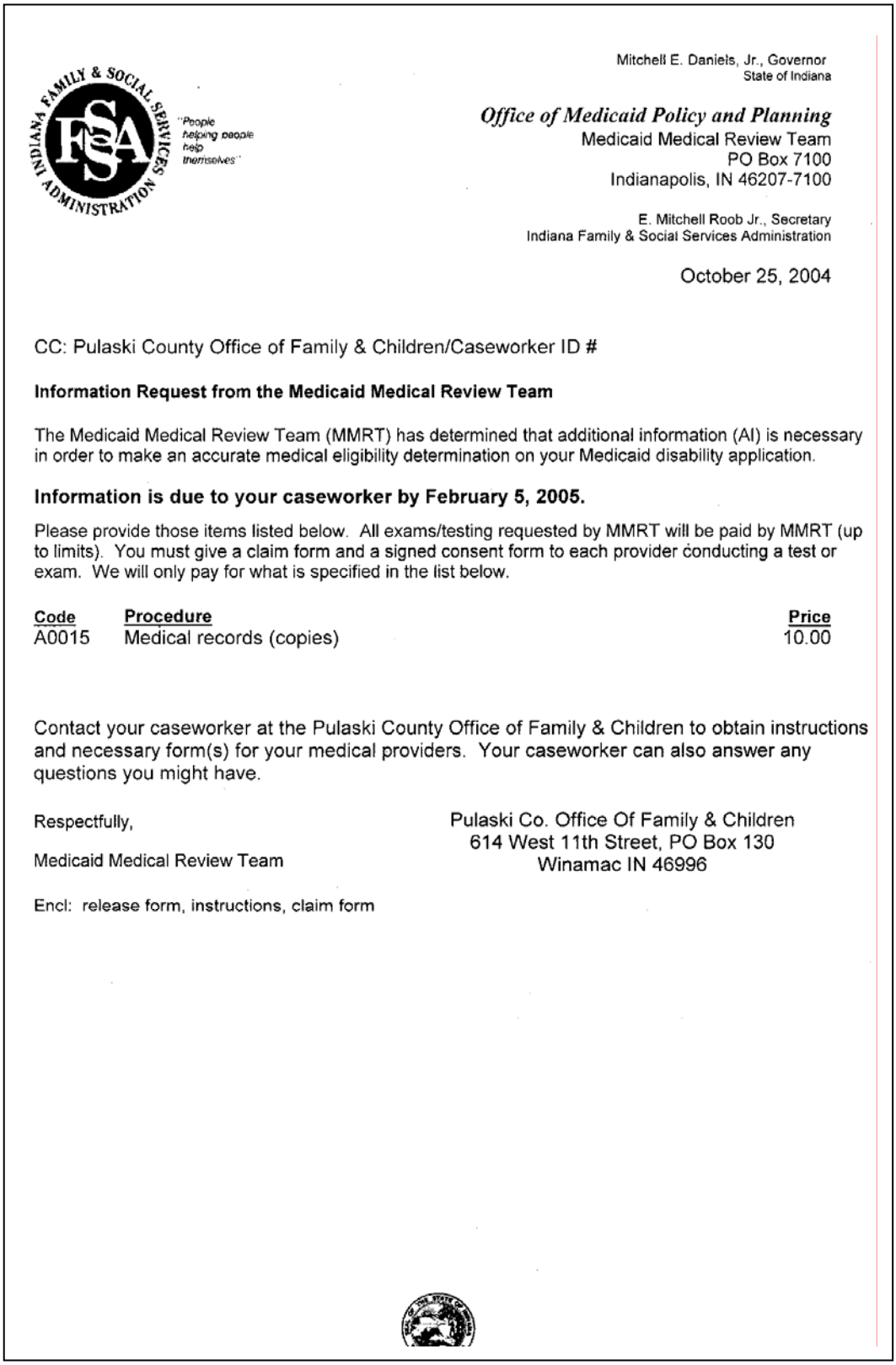
When the County Office receives an application for disability, the caseworker advises the applicant of the information that must be to be provided to the Medical Review Team. One physical or mental status exam is allowed with each Medicaid disability application per provider per member. If the provider exceeds this allotment, the provider must receive approval from the MRT to claim further reimbursement.

The following procedure codes are used to report most initial exams:

- 99080 – Reports
- 99450 – Physical Exam
- 90801 SE – Mental Status Exam
- S9981 – Medical Records

Authorization of Additional Services

If additional exams or tests are required, the MRT directs the member to obtain those services. The MRT's authorization is necessary to ensure that funding is expended only for those services that are appropriate. Members may request this approval in writing or by telephone. The MRT will provide the member with an *Additional Information Request* (shown in Figure 1) to authorize these additional services. All other charges will be denied unless the provider obtains prior authorization from the MRT. Providers should direct questions to the MRT by telephone at (317) 232-2028 (Medical) or (317) 233-5725 (Psychiatric).



Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
Medicaid Medical Review Team
PO Box 7100
Indianapolis, IN 46207-7100

E. Mitchell Roob Jr., Secretary
Indiana Family & Social Services Administration

October 25, 2004

CC: Pulaski County Office of Family & Children/Caseworker ID #

Information Request from the Medicaid Medical Review Team

The Medicaid Medical Review Team (MMRT) has determined that additional information (AI) is necessary in order to make an accurate medical eligibility determination on your Medicaid disability application.

Information is due to your caseworker by February 5, 2005.

Please provide those items listed below. All exams/testing requested by MMRT will be paid by MMRT (up to limits). You must give a claim form and a signed consent form to each provider conducting a test or exam. We will only pay for what is specified in the list below.

Code	Procedure	Price
A0015	Medical records (copies)	10.00

Contact your caseworker at the Pulaski County Office of Family & Children to obtain instructions and necessary form(s) for your medical providers. Your caseworker can also answer any questions you might have.

Respectfully,

Medicaid Medical Review Team

Encl: release form, instructions, claim form

Pulaski Co. Office Of Family & Children
614 West 11th Street, PO Box 130
Winamac IN 46996

Figure 1 – Sample Additional Information Request

Billing Procedures

This section provides billing and claim processing guidelines for MRT providers. MRT claims use IHCP claim processing billing procedures, although there may be minor differences, as follows:

- MRT claims must be submitted via a paper CMS-1500 claim form, Web interChange, or the 837P transaction within one year of the date of service. Providers must properly identify and itemize all services rendered.
- Claims submitted on paper should be submitted on standard Centers for Medicare and Medicaid Services (CMS)-approved paper CMS-1500 claim forms.
- All providers must be valid participants in the MRT program.
- Providers should submit paper CMS-1500 claim forms to the following address:

  EDS CMS-1500 Claims
  P.O. Box 7269
  Indianapolis, IN 46207-7269

- Providers submitting claims via the Web interChange must meet the technical requirements for Web interChange access, and have a valid Web interChange account and password. Providers should allow five business days to process each new Web account. Providers who currently have a Web interChange account and password do not need an additional account and password to submit claims for MRT.
- New providers who wish to use the 837P transaction must complete, submit, and obtain prior approval of their vendor's software, trading partner ID, login ID, and password. Providers should allow one week to process vendor and account information. Providers may obtain instructions for account setup by obtaining a copy of the *Companion Guide – 837 Professional Claims and Encounters Transaction* from the IHCP Web site at http://www.indianamedicaid.com.

  Note: Providers who currently transmit claims using the 837P transaction are not required to make a second application.

- MRT claims cannot be submitted for payment with a claim for Medicaid or services for any other IHCP program. MRT claims must be submitted with the unique MRT member identification number.
- MRT claims are subject to all edits and audits not excluded by MRT program requirements.
- Providers can bill for partial units of service.
- MRT financial information is available in the electronic 835 RA transaction.
- Effective July 1, 2005, MRT claims processing information will be reflected on the 276/277 Claim Status Request and Response Transactions. Providers will be able to inquire on the claims status request and response using Web interChange.
- At no time will an applicant bear financial responsibility for an MRT claim if the services were requested by the MRT or county caseworker. MRT claims are paid even if the disability application is denied.

Transportation

The MRT program will reimburse for transportation services in cases of financial hardship when no transportation is available for medically necessary examinations or tests; however, the provider must contact the MRT to obtain approval prior to rendering the service.

Only the following codes will be authorized and billed for most trips:

> *Note: These codes are different from transportation codes used in the IHCP.*

- *T2003 SE – Non-emergency transportation, encounter, trip* - $10 each way, regardless of vehicle type
- *T2007SE – Transportation waiting time, air ambulance and non-emergency vehicles, ½ hour increments* - $4.50.
- *A0425 SE – Ground mileage, per statute mile* - $1.25.

For billing purposes, a trip is defined as the act of transporting a member from the initial point of pickup to the drop-off point at the final destination.

Transportation providers are expected to transport the member along the shortest and most efficient route to and from the destination.

The following are the reimbursement guidelines for transportation in the MRT program:

- Providers must bill for all mileage, including the first 10 miles. Claim payment is automatically reduced to prevent payment for the first 10 miles one way. Claims billed for mileage of 10 miles or less one way are denied.
- Providers must bill on one claim form for all transportation services provided to the member on the same date of service.
- Providers must maintain supporting documentation to support billed transportation services. For example, the provider must maintain the date of service, member name and address, member identification number, pick up and drop off destinations, service provider name and address, vehicle odometer at the beginning and end of trip, and an indication of one way or round trip.

Voids and Replacements

With the implementation of the electronic voids and replacement process, providers can submit a request to void or replace claim information electronically. Detailed information about voids and replacements is forthcoming on the IHCP Web site.

Web interChange Overview

Web interChange is a fast, free, and interactive Web application that allows providers to submit MRT claims, review processed claims, and in the future, verify member eligibility. Web interChange features on-line help text, frequently asked questions, and *Show Me More* functionality to access information previously available through Web interChange. Web interChange is HIPAA-compliant for direct data entry (DDE) because it provides a secure site with Encryption and Secured Socket Layer (SSL) connections to protect data during transmission. Microsoft Internet Explorer 6.0 or above is required.

The following are some of the features of Web interChange:

- *Claims Inquiry* allows providers to inquire about previously submitted claims – even before they make it to the RA summary or transaction. When EDS receives claims electronically through Web interChange, they are accessible within two hours and remain accessible for three years. Providers may search for claims using a date range, claim type, member ID, or ICN. When the basic claim information displays in Web interChange, the provider clicks the desired claim for more detail. To meet CMS HIPAA privacy requirements, built-in security features only allow billing providers to view the claims that they submit.

- *Eligibility Inquiry* (coming in the future) will allow providers to inquire about member eligibility using the member's MRT ID number, Social Security Number, Medicare number, or name and date of birth. The response will provide the same information a provider obtains from the Automated Voice-Response (AVR) or the OMNI swipe card system.
- *Claim Submission* allows providers to submit MRT claims electronically to the IHCP. **MRT claims are a professional claim type**.
- *Check Inquiry* allows the provider to inquire about previously received payments. The provider can find checks or electronic funds transfers (EFTs) by searching within a date range or by a specific check number. Basic check information displays and the provider clicks on that line to obtain a list of all claims associated with that check. Built-in security features allow only the billing provider to view the checks they have received.

Providers can access Web interChange from the IHCP Web site at https://interchange.indianamedicaid.com.

To apply for a Web interChange user ID and password, providers must complete the access request form available at https://interchange.indianamedicaid.com. The provider should print the form and mail it to the address shown on the form. Providers will be notified via e-mail when the application is approved.

> *Note: The tax identification number (TIN) listed on this form must match the TIN in the provider's file before the request can be completed.*

Providers should direct questions about accessing Web interChange to the EDS Electronic Solutions Helpdesk by telephone at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182 or by e-mail at INXIXElectronicSolutions@eds.com.

To successfully submit a claim to Web interChange, all fields marked with an asterisk in Figure 2 are required.

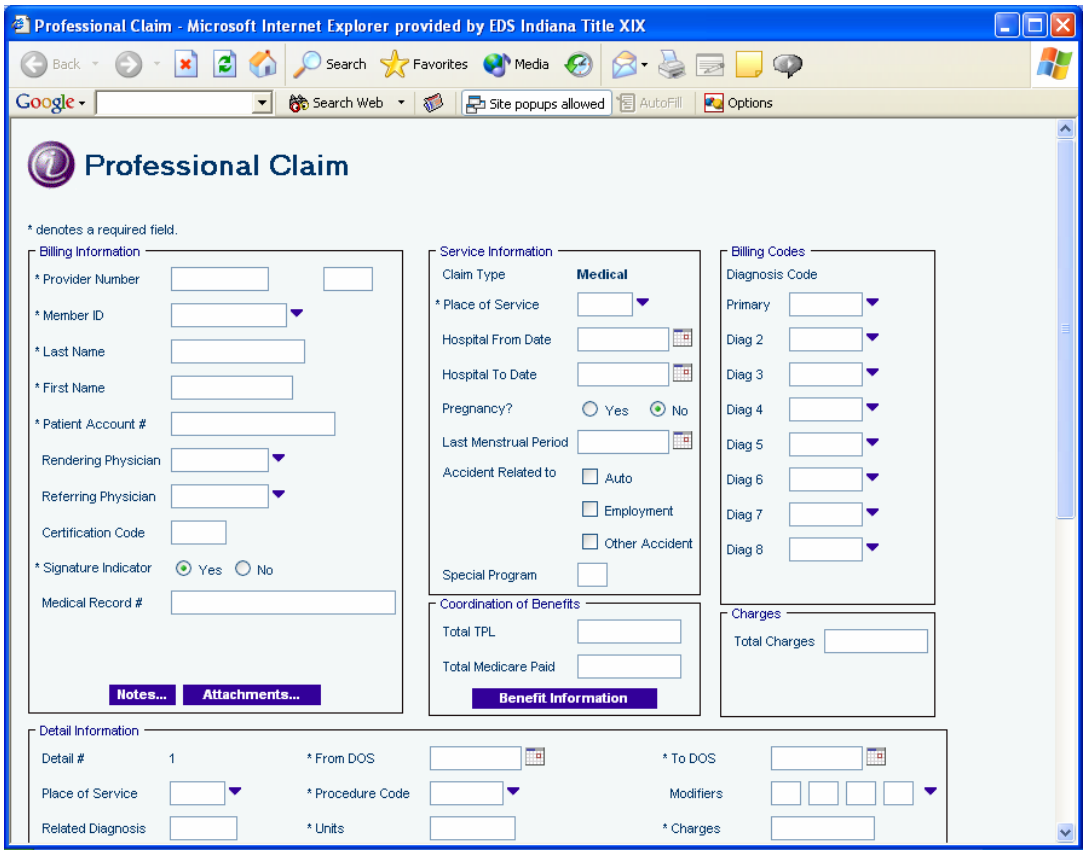


Figure 2 – Web InterChange Claim Submission Window

Web Claim Print

Providers may print claims submitted via Web interChange. To print a claim, a provider should follow these steps after submitting the claim:

1. Upon submitting a claim, the **Claim Confirmation** window appears. This window displays the claim's assigned internal control number (ICN), the member's name, and the total charges for the claim. Click the **Print Claim** button on this window.
2. The **Claim Print** window displays all of the information that was entered into the claim form. Click the **Print Claim** button in the top-right corner of the window.
3. A **Print** window displays options to select the desired printer, number of prints, and other print settings. After making the appropriate selections, click the **Print** button to begin printing the submitted claim.
4. Click the **Close** button in the top-right corner of the claim print window to close the print window. Note that when this **Claim Print** window closes, the claim can only be printed from **Claim Inquiry**.

> *Note: If the submitted claim being printed is a copied claim, clicking the **Close** button on the **Claim Confirmation** window or **Claim Print** window will also close the **Claim Submission** window.*

837 Professional Claims and Encounters Transaction

The ASC X12N 837 (04010X098) transaction and 004010X098A1 Addendum are the HIPAA mandated instruments by which professional claim or encounter data must be submitted. If a professional claim is submitted electronically, the claim must use this transaction. Data files are transmitted in an electronic envelope. The communication envelope consists of the interchange envelope and any functional groups.

After the 837P transaction is submitted, the transaction is checked for compliance. Then, one 997 Functional Acknowledgement file per transaction and a Biller Summary Report (BSR), for all transactions received in a file, are created in response to the 837 submission. The report provides summary information about the results of the pre-adjudication of the claim or encounter being processed. Information on this report indicates rejected claims not processed by the system.

Providers submitting the 837P can find claim submission instructions in the *Companion Guide – 837 Professional Claims and Encounters Transaction* on the IHCP Web site.

Remittance Advice

On a weekly cycle, Indiana*AIM* generates an RA that contains the status of each processed claim at that point:

- The RA displayed in the electronic 835 RA Transaction format contains paid and denied claims.
- The paper RA lists paid, denied, in-process, and adjusted claims.
- Claim Correction Forms (CCFs) are also included with the paper RA.
- The last paper RA of the month includes information about all claims and replacements not processed to a paid or denied status.
- Adjusted claims only appear one time on the RA, when they are either paid or denied.

Additional RA information is included in Chapter 12 of the *IHCP Provider Manual*.

Table 1 provides information to help providers select the procedure code that best describes the most commonly rendered services. When providers have questions about procedure codes used for MRT services and/or RBRVS/Max Fee Schedule, or require clarification about a specific code, they should follow the appropriate avenue of resolution listed in Chapter 1 of the *IHCP Provider Manual*.

Table 1 – MRT Procedure Codes and Fee Schedule

MRT Code	Replacement Code	Description	MRT Rate
Mental Status 1 Unit = 1 Hour (Partial Unit Billing Allowed)	90801 SE	**90801**: Psychiatric diagnostic interview examination including history, mental status, or disposition **SE**: State and/or Federally funded programs/services Max: 1.5 hours	$80.00 per hour
IQ Eval 1 Unit = 1 Hour (Partial Unit Billing Allowed)	96100 SE U1	**96100**: Psychological testing (includes psycho diagnostic assessment of personality) **SE**: State and/or Federally funded programs/services **U1**: IQ Evaluation	$80.00 per hour

(Continued)

MRT Code	Replacement Code	Description	MRT Rate
Psychological Testing 1 Unit = 1 Hour (Partial Unit Billing Allowed)	96100 SE U2	**96100**: Psychological testing (includes psycho diagnostic assessment of personality) **SE**: State and/or Federally funded programs/services **U2**: Psychological Testing	$80.00 per hour
Report (1 Unit Limit)	99080	**99080**: Special reports as insurance forms, or review of medical data to clarify a patient's stay	$10.00
Physical Exam (1 Unit Limit)	99450	**99450**: Basic Life and/or Disability Exam – measure height, weight & BP; medical history;urinalysis, collection of blood samples and/or urinalysis; completion of documents/forms	$65.00
Eye Exam (1 Unit Limit)	92002 SE	**92002** (Initial): Ophthalmologic Services: Medical Examination with initiation of diagnostic and treatment program; intermediate, new patient **SE**: State and/or Federally funded programs/services	$29.00
Eye Exam (1 Unit Limit)	92012 SE	**92012 (Established):** Ophthalmologic services: medical examination and evaluation, with initiation of continuation of diagnostic and treatment program; intermediate established patient **SE**: State and/or Federally funded programs/services	$29.00
Records	S9981	**S9981**: Medical records copying fee, Administrative	$10.00
N/A	T2003 SE	Non-emergency transportation; encounter/trip each way regardless of vehicle type **SE**: State and/or Federally funded programs/services	$10.00
N/A	T2007 SE	Transportation awaiting time, air ambulance and non-emergency vehicles, ½ hour increments **SE**: State and/or Federally funded programs/services	$4.50
N/A	A0425 SE	Ground mileage, per statute mile **SE**: State and/or Federally funded programs/services	$1.25

CMS-1500 Claim Form Requirements

This section provides instructions for completing the CMS-1500 claim form for MRT. Some information is required to complete the claim form, while other information is optional.

The data required on the paper CMS-1500 claim form corresponds to the requirements for submitting the electronic 837P transaction. All data elements a provider submits may not be used for claim processing; however, they may be required for HIPAA-compliant electronic transactions such as the *277 Health Care Claim Status Response* and the *835 Health Care Claim Payment/Advice* transactions.

Each field indicates if the field is required, required if applicable, optional, or not applicable.

These instructions are also printed in the Version 5.1 of *IHCP Provider Manual*, published March 2005.

Instructions for the submission of the 837P transaction are printed in the *Companion Guide – 837 Professional Claims and Encounters Transaction* on the IHCP Web site.

Please complete the sections as indicated in Table 2 for MRT claims

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
1	**INSURANCE CARRIER SELECTION** – Mark Medicaid. **Required.**	X	
1a	**INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM** 1) – Provide the member MRT ID number. Must be 12 digits. (For MRT claims, this is **850** + member's Social Security Number (SSN)) **Required.**	X	
2	**PATIENT'S NAME** (Last Name, First Name, Middle Initial) – Provide the member's last name, first name, and middle initial. **Required**.	X	
3	PATIENT'S BIRTH DATE – Provide the member's birth date in MMDDYY format. Optional. SEX – Mark the appropriate box. Optional.		X
4	INSURED'S NAME (Last Name, First Name, Middle Initial) – Not applicable. The IHCP member is always the insured.		X
5	PATIENT'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE (include Area Code) – Provide the member's complete address information. Optional.		X
6	PATIENT RELATIONSHIP TO INSURED – Not applicable.		X
7	INSURED'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE (INCLUDE AREA CODE) – Not applicable.		X
8	PATIENT STATUS – Mark the appropriate box. Optional.		X
Fields 9 and 9a–9d indicate policyholder information for individuals other than the member, such as another person who is court ordered to provide insurance for the member. These fields also provide additional member insurance information for members with more policies than field 11 and fields 11a through 11d can accommodate. Fields 9 and 9a – 9d do not apply to MRT Billing. Fields 10 and 10a – 10d do not apply to MRT Billing.			
9	**OTHER INSURED'S NAME** (Last Name, First Name, Middle Initial) – If other insurance is available, and the policyholder is other than the member shown in fields 1a and 2, provide the policyholder's name. **Required, if applicable**.		X
9a	**OTHER INSURED'S POLICY OR GROUP NUMBER** – If other insurance is available, and the policyholder is other than the member noted in fields 1a and 2, provide the policy and group number. **Required, if applicable**.		X
9b	**OTHER INSURED'S DATE OF BIRTH** – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, provide the requested policyholder birth date in MMDDYY format. **Required, if applicable.** SEX – Mark the appropriate box. Optional.		X
9c	**EMPLOYER'S NAME OR SCHOOL NAME** – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, provide the requested policyholder information. **Required, if applicable.**		X
9d	**INSURANCE PLAN NAME OR PROGRAM NAME** – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, provide the policyholder's insurance plan name or program name information. **Required, if applicable.**		X
10	**IS PATIENT'S CONDITION RELATED TO** – Mark the appropriate box in each of the four categories. This information is needed for follow-up third party recovery actions. **Required, if applicable.**		X
10a	**EMPLOYMENT? (CURRENT OR PREVIOUS)** – Mark Yes or No. **Required, if applicable.**		X

(Continued)

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
10b	**AUTO ACCIDENT?** – Mark Yes or No. **Required, if applicable.** **PLACE (State)** – Use the two-character state code. **Required, if applicable.**		X
10c	**OTHER ACCIDENT?** – Mark Yes or No. **Required, if applicable.**		X
10d	RESERVED FOR LOCAL USE – Not applicable.		X
	Fields 11 and 11a through 11d provide member insurance information. Fields 11 and 11a through 11d do not apply to MRT billing		
11	**INSURED'S POLICY GROUP OR FECA NUMBER** – Provide the member's policy and group number of the other insurance. **Required, if applicable.**		X
11a	INSURED'S DATE OF BIRTH – Provide the member's birth date in MMDDYY format. **Required, if applicable.** **SEX** – Mark the appropriate box. **Required, if applicable.**		X
11b	**EMPLOYER'S NAME OR SCHOOL NAME** – Provide the requested member information. **Required, if applicable.**		X
11c	**INSURANCE PLAN NAME OR PROGRAM NAME** – Provide the member's insurance plan name or program name. **Required, if applicable.**		X
11d	**IS THERE ANOTHER HEALTH BENEFIT PLAN?** Mark Yes or No. If the response is Yes, complete Fields 9a–9d. **Required, if applicable.**		X
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – Use this field for Claim Note Text. *Note: The claim note text field will not be used systematically for claim processing at this time. Monitor future provider publications for the implementation of this requirement.*		X
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – Not applicable.		X
14	**DATE OF CURRENT ILLNESS (First symptom date) OR INJURY (Accident date) OR PREGNANCY (LMP date)** – Use the date of the last menstrual period for pregnancy related services in MMDDYY format. **Required, if applicable.**		X
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, PROVIDE FIRST DATE – Not applicable.		X
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** – If Field 10a is Yes provide the applicable FROM and TO dates in a MMDDYY format. **Required, if applicable.**		X
17	**NAME OF REFERRING PHYSICIAN OR OTHER SOURCE** – Provide the name of the referring physician (including the primary physician of a lock-in or restricted card member), case manager for Waiver related services, or PrimeStep (Hoosier Healthwise or Medicaid Select) Primary Care Case Management (PCCM) primary medical provider (PMP). **Required, if applicable.** *Note: The term referring provider includes those physicians primarily responsible for the authorization of treatment for lock-in or restricted card members.*		X
17a	**I.D. NUMBER OF REFERRING PHYSICIAN** – Use the IHCP provider number of the referring physician (including the primary physician of a lock-in or restricted card member), case manager for Waiver related services, or PrimeStep (Hoosier Healthwise or Medicaid Select) PCCM PMP. **Required, if applicable.** *Note: The term referring provider includes those physicians primarily responsible for the authorization of treatment for lock-in or restricted card members.*		X

(Continued)

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** – Provide the requested FROM and TO dates in MMDDYY format. **Required, if applicable.**		X
19	**RESERVED FOR LOCAL USE** – Use the Hoosier Healthwise or Medicaid Select PMP two-digit alphanumeric certification code. **Required for PrimeStep PCCM members.**		X
20	OUTSIDE LAB? – Mark the appropriate box. Optional. $CHARGES – Eight-digit numeric field. Optional.		X
21.1–21.4	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** – Complete Fields 21.1, 21.2, 21.3, and 21.4. Use the ICD-9-CM diagnosis codes in priority order. Four codes are allowed. At least one diagnosis code is required for all claims except claims for Waiver, transportation, and medical equipment/supply services. **Required.**		X
	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – Complete Fields 21.1, 21.2, 21.3, and 21.4. Use the ICD-9-CM diagnosis codes in priority order. Four codes are allowed. At least one diagnosis code is required for all claims except claims for Waiver, transportation, and medical equipment/supply services. **Required.**		X
22	MEDICAID RESUBMISSION CODE, ORIGINAL REF. NO. – Not applicable. For crossover claims, the combined total of the Medicare coinsurance, deductible, and psych reduction must be reported on the left hand side of field 22 under the heading Code. The Medicare paid amount (actual dollars received from Medicare) must be submitted in field 22 on the right hand side under the heading Original Ref No.		X
23	PRIOR AUTHORIZATION NUMBER – The prior authorization (PA) number is not required, but use is recommended to track services that require PA. Optional.		X
Date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. For services requiring authorization, the FROM date of service cannot be prior to the date the service was authorized. The TO date of service cannot exceed the date the specific service was terminated. For multiple services over a span of time, which apply to the same procedure code, the following apply: If the dates of service are consecutive, for example, one service per day, the FROM and TO dates of service can include the span of time with respective service units indicated in field 24g. Example – One unit of service per day for five days is submitted FROM 100102 TO 100502 for five units. If the dates of service are non-consecutive, each date of service is indicated on a separate line. Example – one service on each of the following days: 100102, 100502, 100602, and 101502 are not submitted FROM 100102 TO 101502. Rather, 100102 and 101502 are submitted on individual service lines with one unit of service each and 100502 through 100602 are submitted with two units of service on the same line.			
24A	**DATE OF SERVICE** – Provide the FROM and TO dates in MMDDYY format. Up to six date ranges are allowed per form. **Required.**	X	
24B	**Place of Service** – Use the POS code for the facility where services were rendered. **Required.** For a complete listing of POS codes, see http://cms.hhs.gov/states/poshome.asp or Table 3.	X	
24C	Type of Service – Not applicable.		X
24D	**PROCEDURES, SERVICES, OR SUPPLIES**	X	
	CPT/HCPCS – Use the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line. **Required.**	X	

(Continued)

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
	MODIFIER – Use the appropriate modifier, if applicable. Up to four modifiers are allowed for each procedure code. **Required, if applicable.**	X	
24E	**DIAGNOSIS CODE** – Use number 1 through 4 corresponding to the applicable diagnosis codes in field 21.1 through 21.4. A minimum of one and a maximum of four diagnosis code references are allowed on each line. **Required.**		X
24F	**$ CHARGES** – Provide the total amount charged for the procedure performed, based on the number of units indicated in field 24G. The charged amount is the sum of the total units multiplied by the single unit charge. Each line is computed independently of other lines. This is an eight-digit field. **Required.**	X	
24G	**DAYS OR UNITS** – Provide the number of units being claimed for the procedure code. Six digits are allowed, and 9999.99 units is the maximum that can be submitted. The procedure code may be submitted in partial units, if applicable. **Required.**	X	
24H	**EPSDT Family Plan** – If the patient is pregnant, indicate with a P in this field on each applicable line. **Required, if applicable.**		X
24I	**EMG** – Emergency indicator. This field indicates services were for emergency care for service lines with a CPT/HCPCS code in field 24D. Indicate Y for yes or N for no. **Required, if applicable.**		X
24J	COB – Not Applicable (Used for EPSDT)		X
24K	**RESERVED FOR LOCAL USE** – Provide the rendering provider number of the group member, or the sole proprietor number. The entire nine-digit number and one alphabetic character location code must be used. If billing for case management, the case manager's number must be entered here. If billing for mid-level practitioners, the supervising physician's number must be entered here. **Required.**	X	
25	FEDERAL TAX I.D. NUMBER – Not applicable.		X
26	**PATIENT'S ACCOUNT NO**.. – Provide the internal patient tracking number. **Required**.	X	
27	ACCEPT ASSIGNMENT? – The IHCP provider agreement includes details about accepting payment for services. Optional.		X
28	**TOTAL CHARGE** – Provide the total of all service line charges in column 24F. This is an eight-digit field, such as 999999.99. **Required.**	X	
29	**AMOUNT PAID** – Provide payment amounts received from any commercial insurance source. All applicable items are combined and the total provided in this field. This is an eight-digit field. **Required, if applicable.** Other insurance – Provide the amount paid by the other insurer. If the other insurer was billed but paid zero, use 0 in this field. Attach denials to the claim form when submitting the claim for adjudication. Spend-down members – Attach the DPW form 8A to the claim form when submitting the claim adjudication. No deductible amount should be placed in this field.	X	
30	**BALANCE DUE** – Field 28, TOTAL CHARGE minus (–) field 29, AMOUNT PAID (by commercial insurance) equals (=) field 30, BALANCE DUE. This is an eight-digit field, such as 999999.99. **Required.**	X	

(Continued)

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
31	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS** – An authorized person, someone designated by the agency or organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not. Required, unless the Signature on File form has been completed and is included in the provider enrollment file. **DATE –** Provide the date the claim was filed. **Required.**	X	
32	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED, if other than home or office. Indicate the provider's name and address. This field is optional, but helps EDS contact the provider if necessary. Optional.	X	
	All providers in Indiana are issued a unique, individual provider number. Providers associated with a group must have an individual provider number tied to the group provider number. Use the rendering provider number of the group member or sole proprietor number in field 24K. Use the billing number for the group in field 33. Providers not associated with a group (sole proprietors) should use the unique, individual provider number, in fields 32, without the alpha character, and in field 33, with the alpha character, to indicate the service location.	X	
33	**PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE #** – Use the nine numeric and one alpha character billing provider number. If this claim is for a group practice, only the IHCP group provider number should be indicated in this field. **Required.** *Note: Only one IHCP provider number should be indicated in this field.*	X	

Changes Corresponding to the HIPAA-Required 837P Transaction

MRT providers must use the appropriate place of service codes listed in Table 3.

Table 3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name
01-02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Freestanding Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Freestanding Facility
08	Tribal 638 Provider-based Facility
09-10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home*
15	Mobile Unit
16-19	Unassigned

(Continued)

Table 3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance – Land
42	Ambulance – Air or Water
43-48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service