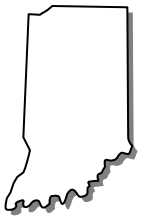

P R O V I D E R B U L L E T I N

B T 2 0 0 6 2 0 — O C T O B E R 2 7 , 2 0 0 6

To: MRT Providers

Subject: Medical Review Team Update

Overview

The purpose of this bulletin is to provide updated information about Medical Review Team (MRT) claims processing. This bulletin includes information about eligibility determinations, member eligibility, an updated list of appropriate procedure codes billable under the MRT program, a list of the top MRT denials and resolution guidelines, and claim submission procedures.

Providers that have specific questions about the content of this bulletin may contact the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis area, or toll free at 1-800-577-1278.

Eligibility Determinations

To make timely determinations about an applicant's alleged disability for coverage through Indiana Medicaid, the MRT directs providers to include the following minimum information for the four most common application diagnoses:

- Back pain
  - Associated surgeries for back pain
  - Medications that the applicant is taking
  - Details about the applicant's level of functioning with the back pain
  - Any additional information about the applicant's back pain
- Depression
  - Associated hospitalizations for depression
  - Medications the applicant is taking
  - Details about the applicant's level of functioning with depression
  - Any additional information about the applicant's depression
- Diabetes
  - Associated neuropathy, nephropathy, or retinopathy
  - Blood sugar levels, HbA1C levels, and other relative lab results
  - Medications the applicant is taking
  - Diabetes flow sheet
  - Details about the applicant's level of functioning with diabetes
  - Additional information about the applicant's diabetes
- Hypertension
  - Associated end organ damage due to hypertension
  - Medications the applicant is taking
  - Details about the applicant's level of functioning with hypertension
  - Any additional information about the applicant's hypertension

Billing Procedures

For providers to be reimbursed for Medicaid disability exams, the MRT directs providers to return all requested information to the County Office, Division of Family Resources (DFR) within 20 days of the date of service. Failure to remit documentation in a timely manner may result in claims processing and reimbursement delays.

Member Eligibility

The County Office, DFR 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 and notifies the County Office, DFR of its decision.

Providers can submit claims electronically using Web interChange from the IHCP Web site at https://interchange.indianamedicaid.com.

The following tables provide information to help providers select the procedure code that best describes the services rendered. When providers have questions about procedure codes used for billing MRT services, the Resource-Based Relative Values Scale (RBRVS)/Maximum Fee Schedule, or require clarification about a specific code, they should follow the appropriate avenue of resolution listed in Chapter 1 of the *Indiana Health Coverage Programs (IHCP) Provider Manual*. The *IHCP Provider Manual* is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications manuals.htm. The standard global billing procedures and edits apply when using these codes.

The complete fee schedule is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp.

Table 1 – MRT Current Procedural Terminology (CPT®) Procedure Codes and Fee Schedule

CPT® Procedure Code	Modifier	Procedure Code Description	Modifier Description	Effective Date MRT Coverage	Allowed Amount	Comments or Special Instructions
36415		Collection of venous blood by venipuncture		07/01/2002	$3.00	
70210		Radiologic examination, sinuses, paranasal; less than three views		07/01/2002	$23.11	
70220		Radiologic examination, sinuses, paranasal; complete, minimum of three views		07/01/2002	$30.83	
71010		Radiologic examination, chest; single view, frontal		07/01/2002	$19.62	
71020		Radiologic examination, chest; two views, frontal and lateral		07/01/2002	$25.03	
71100		Radiologic examination, ribs, unilateral; two views		07/01/2002	$23.88	

(Continued)

Table 1 – MRT Current Procedural Terminology (CPT®) Procedure Codes and Fee Schedule

CPT® Procedure Code	Modifier	Procedure Code Description	Modifier Description	Effective Date MRT Coverage	Allowed Amount	Comments or Special Instructions
71250		Computed tomography, thorax; without contrast material		07/01/2002	$200.09	
71260		Computerized tomography, thorax; with contrast material(s)		07/01/2002	$233.40	
72040		Radiologic examination, spine, cervical; two or three views		07/01/2002	$24.51	
72050		Radiologic examination, spine, cervical; minimum of four views		07/01/2002	$35.76	
72052		Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies *		07/01/2002	$44.05	
72069		Radiologic examination, spine, thoracolumbar, standing (scoliosis)		07/01/2002	$21.78	
72070		Radiologic examination, spine; thoracic; two views		07/01/2002	$25.81	
72072		Radiologic examination, spine; thoracic; three views *		07/01/2002	$28.03	
72074		Radiologic examination, spine; thoracic; minimum of four views		07/01/2002	$32.58	
72080		Radiologic examination, spine; thoracolumbar; two views		07/01/2002	$26.33	
72100		Radiologic examination, spine, lumbosacral; two or three views		07/01/2002	$26.33	
72110		Radiologic examination, spine, lumbosacral; minimum of four views		07/01/2002	$36.28	
72114		Radiologic examination, spine, lumbosacral; complete, including bending views		07/01/2002	$45.34	
72170		Radiologic examination, pelvis; one or two views		07/01/2002	$20.37	
72200		Radiologic examination, sacroiliac joints; less than three views		07/01/2002	$20.63	
72202		Radiologic examination, sacroiliac joints; three or more views		07/01/2002	$23.93	
72220		Radiologic examination, sacrum and coccyx; minimum of two views		07/01/2002	$21.82	
73020		Radiologic examination, shoulder; one view		07/01/2002	$18.52	

(Continued)

Table 1 – MRT Current Procedural Terminology (CPT®) Procedure Codes and Fee Schedule

CPT® Procedure Code	Modifier	Procedure Code Description	Modifier Description	Effective Date MRT Coverage	Allowed Amount	Comments or Special Instructions
73030		Radiologic examination, shoulder; complete, minimum of two views		07/01/2002	$22.10	
73060		Radiologic examination, humerus; minimum of two views		07/01/2002	$21.82	
73070		Radiologic examination, elbow; two views		07/01/2002	$19.81	
73080		Radiologic examination, elbow, complete; minimum of three views		07/01/2002	$21.82	
73090		Radiologic examination, forearm; two views		07/01/2002	$20.09	
73100		Radiologic examination, wrist; two views		07/01/2002	$19.32	
73110		Radiologic examination, wrist; complete, minimum of three views		07/01/2002	$20.89	
73120		Radiologic examination, hand; two views		07/01/2002	$19.32	
73130		Radiologic examination, hand; minimum of three views		07/01/2002	$20.89	
73500		Radiologic examination, hip; unilateral, one view		07/01/2002	$19.34	
73510		Radiologic examination, hip; complete, minimum of two views		07/01/2002	$23.46	
73520		Radiologic examination, hips, bilateral; minimum of two views of each hip, including anteroposterior view of pelvis *		07/01/2002	$28.11	
73550		Radiologic examination, femur; two views		07/01/2002	$21.82	
73560		Radiologic examination, knee; one or two views		07/01/2002	$20.37	
73562		Radiologic examination, knee; three views		07/01/2002	$22.36	
73564		Radiologic examination, knee; complete, four or more views		07/01/2002	$25.18	
73565		Radiologic examination, knee; both knees, standing, anteroposterior		07/01/2002	$19.60	
73590		Radiologic examination, tibia and fibula; two views		07/01/2002	$20.37	
73600		Radiologic examination, ankle; two views		07/01/2002	$19.32	

(Continued)

Table 1 – MRT Current Procedural Terminology (CPT®) Procedure Codes and Fee Schedule

CPT® Procedure Code	Modifier	Procedure Code Description	Modifier Description	Effective Date MRT Coverage	Allowed Amount	Comments or Special Instructions
73610		Radiologic examination, ankle; complete, minimum of three views		07/01/2002	$20.89	
73620		Radiologic examination, foot; two views		07/01/2002	$19.32	
73630		Radiologic examination, foot; complete, minimum of three views		07/01/2002	$20.89	
74000		Radiologic examination, abdomen; single anteroposterior view		07/01/2002	$20.91	
74020		Radiologic examination, abdomen; complete, including decubitus and/or erect views		07/01/2002	$27.36	
74022		Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views; single view chest		07/01/2002	$32.27	
80048		Basic metabolic panel		07/01/2002	$8.83	
80053		Comprehensive metabolic panel		07/01/2002	$14.39	
80061		Lipid profile		07/01/2002	$18.51	
80076		Hepatic function panel		07/01/2002	$8.83	
80100		Drug screen, qualitative; multiple drug classes, chromatographic method; each procedure		07/01/2002	$20.10	
80164		Dircpylacetic acid (valproic acid)		07/01/2002	18.72	
82150		Amylase		07/01/2002	$8.96	
82465		Cholesterol, serum or whole blood; total		07/01/2002	$6.02	
82565		Creatinine; blood		07/01/2002	$7.07	
82575		Creatinine; clearance		07/01/2002	$13.06	
82947		Glucose; quantitative, blood (except reagent strip)		07/01/2002	$5.42	
83036		Hemoglobin; glycosylated (AIC)		07/01/2002	$13.42	
83690		Lipase		07/01/2002	$5.27	
83718		Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)		07/01/2002	$11.31	
84436		Thyroxine, total		07/01/2002	$9.50	
84443		Thyroid stimulating hormone (TSH)		07/01/2002	$23.21	
84450		Transferase; aspartate amino (AST) (SGOT)		07/01/2002	$7.14	

(Continued)

Table 1 – MRT Current Procedural Terminology (CPT®) Procedure Codes and Fee Schedule

CPT® Procedure Code	Modifier	Procedure Code Description	Modifier Description	Effective Date MRT Coverage	Allowed Amount	Comments or Special Instructions
84460		Transferase; alanine amino (ALT) (SGPT)		07/01/2002	$7.32	
84478		Triglycerides		07/01/2002	$7.95	
84479		Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)		07/01/2002	$11.42	
84550		Uric acid; blood		07/01/2002	$6.25	
85018		Blood count; hemoglobin (Hgb)		07/01/2002	$3.27	
85025		Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count		07/01/2002	$10.74	
85651		Sedimentation rate, erythrocyte; non-automated		07/01/2002	$4.91	
85652		Sedimentation rate, erythrocyte; automated, Westergren test		07/01/2002	$3.73	
86361		T cells; absolute CD4 count		07/01/2002	$37.00	
86430		Rheumatoid factor; qualitative		07/01/2002	$7.85	
86707		Hepatitis Be antibody (HBeAB)		07/01/2002	$6.43	
86708		Hepatitis A antibody (HAAB); total		07/01/2002	$17.12	
86803		Hepatitis C antibody		07/01/2002	$19.73	
90801	SE	Psychiatric diagnostic interview examination	SE -State and/or federally-funded programs/ service	07/01/2002	$80.00 per hour	Mental status One unit = one hour (Partial unit billing allowed)
92002	SE	**New:** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	SE - State and/or federally-funded programs/ services	07/01/2002	$29.00	Eye exam One unit limit
92012	SE	**Established:** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	SE - State and/or federally-funded programs/ services	07/01/2002	$29.00	Eye exam One unit limit
92015		Determination of refractive state		07/01/2002	$10.47	

(Continued)

Table 1 – MRT Current Procedural Terminology (CPT®) Procedure Codes and Fee Schedule

CPT® Procedure Code	Modifier	Procedure Code Description	Modifier Description	Effective Date MRT Coverage	Allowed Amount	Comments or Special Instructions
92083		Visual field extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus programs G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)		07/01/2002	$36.64	
92551		Screening test; pure tone, air only		07/01/2002	$11.42	
92552		Pure tone audiometry (threshold); air only		07/01/2002	$11.47	
92553		Pure tone audiometry (threshold); air and bone		07/01/2002	$17.60	
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)		07/01/2002	$31.43	
93000		Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report		07/01/2002	$20.63	
93010		Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only		07/01/2002	$9.06	
94010		Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s) with or without maximal voluntary ventilation		07/01/2002	$23.11	
94060		Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration		07/01/2002	$37.43	
95816		Electroencephalogram (EEG); including recording awake and drowsy		07/01/2002	$72.61	
95819		Electroencephalogram (EEG); including recording awake and asleep		07/01/2002	$78.72	
95860		Needle electromyography; one extremity with or without related paraspinal areas		07/01/2002	$57.01	
95861		Needle electromyography; two extremities with or without related paraspinal areas		07/01/2002	$97.63	

(Continued)

Table 1 – MRT Current Procedural Terminology (CPT®) Procedure Codes and Fee Schedule

CPT® Procedure Code	Modifier	Procedure Code Description	Modifier Description	Effective Date MRT Coverage	Allowed Amount	Comments or Special Instructions
95863		Three extremities with or without related paraspinal areas		07/01/2002	$115.98	
95864		Four extremities with or without related paraspinal areas		07/01/2002	$150.71	
95900		Nerve conduction, amplitude and latency/velocity study; each nerve, motor, without F-wave study		07/01/2002	$28.57	
95903		Nerve conduction, amplitude and latency/velocity study; each nerve, motor, with F-wave study		07/01/2002	$32.84	
95904		Sensory		07/01/2002	$24.51	
96100	**SE**	Psychological testing (includes Psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS R, Rorshach, MMPI) with interpretation and report, per hour	SE - State and/or federally-funded programs/ services	07/01/2002 – **12/31/2005**	$80.00	No longer valid for dates of service after 12/31/2005. **Please refer to procedure code 96101 SE.** One unit = one hour (Partial unit billing allowed)
96101	**SE**	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	SE - State and/or federally funded programs/ services	**01/01/2006**	$80.00	**Replaced** procedure code **96100 SE** Cannot be billed with S9981-Records. Two unit limit/12 months
99080		Special reports as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form		07/01/2002	$10.00	One unit limit
99199		Unlisted special service, procedure or report		07/01/2002	$23.38	
99244		Office consultation for a new or established patient		**01/01/2006**	$96.82	**Replaced** procedure code **99274**
99245		Office consultation for a new or established patient		**01/01/2006**	$130.47	**Replaced** procedure code **99275**

(Continued)

Table 1 – MRT Current Procedural Terminology (CPT®) Procedure Codes and Fee Schedule

CPT® Procedure Code	Modifier	Procedure Code Description	Modifier Description	Effective Date MRT Coverage	Allowed Amount	Comments or Special Instructions
99274		Confirmatory consultation for a new or established patient		07/01/2002 – **12/31/2005**	$82.52	No longer valid for dates of service after 12/31/2005. **Please refer to Procedure code 99244 for billing.**
99275		Confirmatory consultation for a new or established patient		07/01/2002 – **12/31/2005**	$113.69	No longer valid for dates of service after 12/31/2005. **Please refer to Procedure code 99245 for billing.**
99450		Basic life and/or disability examination		07/01/2002	$65.00	Physical exam One unit limit
A0425	SE	Ground mileage, per statute mile	SE - State and/or federally-funded programs/ service	07/01/2002	$1.25	
S9981		Medical records copying fee, administrative		07/01/2002	$10.00	Cannot be billed on the same date as an examination.
T1023		Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter		07/01/2002	Manual Pricing Attachment required	
T2003	SE	Non-emergency transportation; encounter/trip	SE - State and/or federally-funded programs/ services	07/01/2002	$10.00	
T2007	SE	Transportation waiting time, air ambulance and non-emergency vehicle, one-half hour increments	SE - State and/or federally-funded programs/ services	07/01/2002	$4.50	

** American Medical Association. Current Procedural Terminology: CPT 2006, Professional Edition, Revised 2006. Chicago, Illinois: American Medical Association, Chicago, Illinois, 2006.*

Top MRT Claim Denials

EDS monitors claim activity for providers submitting MRT claims. Analysis of the MRT claim activity shows the following explanation of benefit (EOB) codes to be the top five denials for MRT claim submissions. The following are the EOB codes and the appropriate billing guidelines that must be followed for correcting the claim denial or resubmitting the claim for reimbursement consideration.

EOB Code 1004 – Rendering provider not enrolled in the program billed for the date of service. Please verify provider number and resubmit.

A provider experiencing this denial must complete the appropriate provider update forms, sign, date, and mail them to the address indicated on the form. These forms are available on the IHCP Web site at http://www.indianamedicaid.com.

A provider must indicate *MRT Program Coverage* in the rendering provider field information. The effective date is retroactive one year from the date of receipt of the signature date on the form. Should providers need the effective date to be greater than one year from the signature date on the form, providers must attach a copy of the oldest claim to ensure that the effective date is entered appropriately.

When the provider receives a confirmation letter stating that the update is complete, the provider can resubmit any previously-denied claims for EOB code 1004 for reimbursement consideration.

EOB Code 228 – Your claim was received without a valid signature and there is no record that a certification form has been received to update your provider file. This claim form must be signed before resubmitting for payment.

This denial occurs because the provider did not complete the *Addendum – Claim Certification Statement for Signature on File* form or submits claims without the appropriate signature on the claim form. The *Addendum – Claim Certification Statement for Signature on File* form is available on the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/pdf ClaimCertification.pdf. Providers who submit paper claims must include the signature of an authorized person, someone designated by the agency or organization. A signature stamp is acceptable; however, a typed name is not. Claims from providers who have a signed certification form on file with EDS will process even when the signature is omitted. The certification form only pertains to the group. If the certification form has already been submitted, it is not necessary to complete this form again. The completed form must be mailed to the following address:

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

EOB Code 4021 – This procedure code is not covered for the dates of service for the program billed. Please verify and resubmit.

In IHCP provider bulletin *BT200514* published June 3, 2005, providers were instructed to use procedure code 96100 SE U1 for billing psychological testing (including psychological diagnostic assessment of personality) one unit per one hour. This procedure code was end-dated in provider bulletin *BT200601* published January 3, 2006, due to the annual update for CPT codes for 2006.

Providers billed procedure code 96101, which was identified as the replacement procedure code for 96100. This procedure code was not established as an appropriate procedure code for MRT claim adjudication; therefore, claims denied for EOB 4021. The IHCP modified the program coverage for procedure code 96101 SE U1 – IQ evaluation, and 96101 SE U2 – Psychological testing, with an effective date of January 1, 2006. Providers may resubmit denied claims for reimbursement consideration.

EOB Code 3001 – Dates of service not on the prior authorization masterfile.

Providers are experiencing this denial when billing procedure code 96101 SE for the date of service and the appropriate program coverage is not available during the claim verification process. The claim also posts EOB 3001 when the provider bills a procedure code for a program and it is not covered because the procedure code billed does not have a prior authorization (PA) on file. As a reminder, providers should bill the appropriate procedure code for the service rendered to ensure that the claim is not inadvertently denied for EOB 3001.

EOB Code 5001 – This is a duplicate of another claim.

The claim being submitted has the same rendering provider number, member number, dates of service, procedure code, and modifier as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Providers that feel their claim has been denied in error, should use Web interChange to verify that the claim has not been previously paid. Providers with questions may contact Customer Assistance at (317) 655-3240 in the local Indianapolis area, or toll free at 1-800-577-1278.

Claim Billing Guidelines

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 must be submitted on standard Centers for Medicare & Medicaid Services (CMS)-approved paper CMS-1500 claim forms. A copy of the CMS-1500 claim form is available for download from the CMS Web site at http://www.cms.hhs.gov/cmsforms/downloads/CMS1500.pdf.
- 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 interChange 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. Instructions for account setup are available from the *Companion Guide: 837 Professional Claims and Encounters Transaction* available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/837p.pdf.

> *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 remittance advice (RA) transaction.
- MRT claims processing information is reflected on the 276/277 Claim Status Request and Response Transactions. Providers may use Web interChange to inquire on the claims status request and response.
- At no time does 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.

Information about how to submit claims using Web interChange or the electronic 837P transaction is available on the IHCP Web site at http://www.indianamedicaid.com. The following information is available on the Web site:

- Web interChange instructions are available at https://interchange.indianamedicaid.com/FAQ/faq.asp
- *Companion Guide: Electronic Data Interchange (EDI) Communications* is available at http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/comm.pdf
- The current *IHCP Provider Manual* is available at http://www.indianamedicaid.com/ihcp/Publications/manuals.htm
- The provider relations field consultants listing is available at http://www.indianamedicaid.com/ihcp/ProviderServices/pr_list_frameset.htm

For answers to specific questions, providers can call Customer Assistance at (317) 655-3240 in the Indianapolis area, or toll free at 1-800-577-1278.

Providers can submit specific questions about MRT claims processing in writing to the Written Correspondence Unit. Providers are encouraged to submit questions by completing and mailing the *Indiana Health Coverage Programs Inquiry* form to the following address:

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

Incomplete inquiries are returned for additional information. Providers should allow 10 business days to receive a response. The *Indiana Health Coverage Programs Inquiry* form is available online from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp, or by sending a written request to the following address:

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

Transportation

The MRT program reimburses 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 are 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.

Voids and Replacements

With the implementation of the electronic voids and replacement process, providers can submit an electronic request to void or replace claim information. 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 electronically submit MRT claims, review processed claims, and in the future, verify member eligibility. Web interChange features online help text, frequently asked questions (FAQ), and *Show Me More* functionality to access information previously submitted through Web interChange. Web interChange is Health Information Portability and Accountability Act (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 electronically receives claims through Web interChange, they are accessible within two hours and remain accessible for three years. Providers can search for claims using a date range, claim type, member ID, or internal control number (ICN). When the basic claim information displays in Web interChange, the provider selects a claim and clicks on it to view more detail. To meet CMS HIPAA privacy requirements, system security features allow billing providers to view only the claims that they submit.

- **Claim Submission** allows electronic submission of MRT claims to the IHCP. MRT claims are a professional claim type.
- **Check Inquiry** allows inquiry 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 the billing provider to view only the checks they have received.

Accessing Web interChange

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 *interChange Administrator Request Form* available at https://interchange.indianamedicaid.com/Administrative/InterChange%20Administrator%20Request%20Form.asp. The provider must print the form and mail it to the address shown on the form. Providers are notified via e-mail when the application is approved.

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

Direct questions about accessing Web interChange to the EDS Electronic Solutions Help Desk by telephone at (317) 488-5160 in the Indianapolis local area, or toll free at 1-877-877-5182, or by e-mail at INXIXElectronicSolutions@eds.com.

To submit a claim using Web interChange, all fields marked with an asterisk in Figure 1 are required.

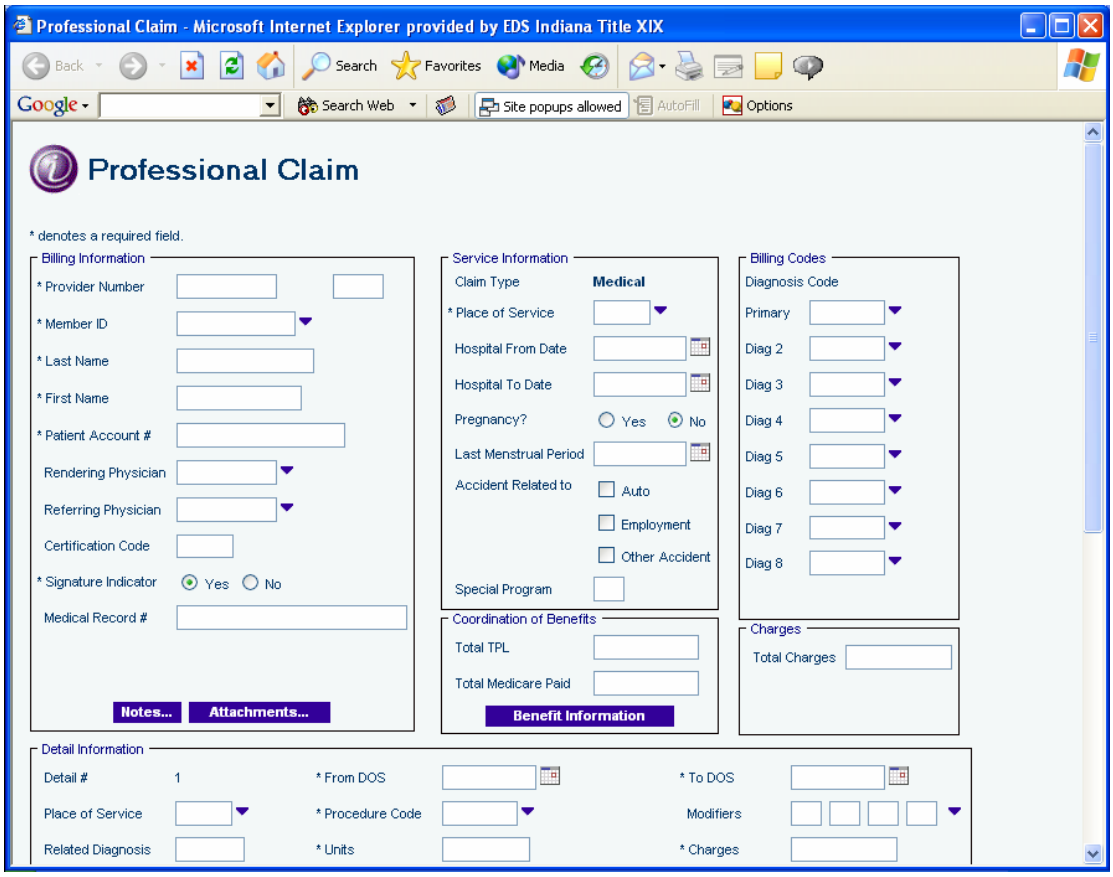

Figure 1 – Web InterChange Claim Submission Window

Web Claim Print

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

1. After submitting a claim, the *Claim Confirmation* window displays. This window shows the claim's assigned 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 print the submitted claim.
4. Click the **Close** button in the top-right corner of the *Claim Print* window to close the window. 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 also closes the* Claim Submission *window.*

837 Professional Claims and Encounters Transaction

The ASC X12N 837 (04010X098) transaction and 004010X098A1 Addendum are the HIPAA-mandated instruments for submission of professional claim or encounter data. This transaction is required for submission of electronic professional claims.

After the provider submits the 837P transaction, the transaction is checked for compliance. One *997 Functional Acknowledgement* file per transaction and a *Biller Summary Report* (BSR) for all transactions received in a file, is 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 at http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/837p.pdf.

Remittance Advice

On a weekly cycle, Indiana*AIM* generates an RA that contains the current status of each processed claim.

- 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*.

CMS-1500 Claim Form Requirements

This section provides instructions for completing the CMS-1500 claim form for the 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.

In Table 2 – CMS-1500 Claim Form Field Locator, the field description indicates if the field is required, optional, or not applicable.

Table 2 is excerpted from provider bulletin *BT200514* and updated with information to be included in the next revision of the *IHCP Provider Manual*.

Instructions for the submission of the 837P transaction are printed in the *Companion Guide: 837 Professional Claims and Encounters Transaction* available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/837p.pdf.

Table 2 – CMS-1500 Claim Form Locator

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
1	**INSURANCE CARRIER SELECTION** – Enter **X** for Traditional Medicaid. **Required.**	X	
1a	**INSURED'S I.D. NUMBER (**FOR PROGRAM IN ITEM 1) – Enter the member MRT ID number. Must be 12 numeric 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 obtained from the automated voice response (AVR) system, electronic claim submission (ECS), Omni, or Web interChange verification. **Required**.	X	
3	PATIENT'S BIRTH DATE – Enter the member's birth date in MMDDYY format. Optional. SEX – Enter an **X** in the appropriate sex block. 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) – Enter 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 – Enter **X** in the appropriate box. Optional.		X
Fields 9 and 9a–9d indicate policyholder information for individuals other than the member, such as if another person is court ordered to provide insurance for the member. These fields can also be used to enter additional member insurance information for those members with more policies than Fields11 and 11a - 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, enter the policyholder's 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 Fields 1a and 2, enter the requested policyholder birth date in MMDDYY format. Optional. SEX – Enter an **X** in 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 Fields 1a and 2, enter 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 Fields 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** – Enter **X** in the appropriate box in each of the three categories. This information is needed for follow-up third party recovery actions. **Required, if applicable.**		X

(Continued)

Table 2 – CMS-1500 Claim Form Locator

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
10a	**EMPLOYMENT?** (CURRENT OR PREVIOUS) – Enter **X** in the appropriate box. **Required, if applicable.**		X
10b	**AUTO ACCIDENT?** – Enter **X** in the appropriate box. **Required, if applicable.** **PLACE (**State**)** – Enter the two-character state code. **Required, if applicable.**		X
10c	**OTHER ACCIDENT?** – Enter **X** in the appropriate box. **Required, if applicable.**		X
10d	RESERVED FOR LOCAL USE – Not applicable.		X
Fields 11 and 11a - 11d are used to enter member insurance information. *Fields 11 and 11a through 11d do not apply to MRT billing*			
11	**INSURED'S POLICY GROUP OR FECA NUMBER** – Enter the member's policy and group number from the other insurance. **Required, if applicable.**		X
11a	**INSURED'S DATE OF BIRTH** – Enter the member's birth date in MMDDYY format (CCYYMMDD) if submitting electronically). **Required, if applicable.** **SEX** – Enter **X** in the appropriate sex block. **Required, if applicable.**		X
11b	**EMPLOYER'S NAME OR SCHOOL NAME** – Enter the requested member information. **Required, if applicable.**		X
11c	**INSURANCE PLAN NAME OR PROGRAM NAME** – Enter the member's insurance plan name or program name. **Required, if applicable.**		X
11d	**IS THERE ANOTHER HEALTH BENEFIT PLAN?** Enter **X** in the appropriate box. 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 is not 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) **OR INJURY** (Accident) **OR PREGNANCY** (LMP) – Enter the requested information in MMYYDD. **Required for payment for pregnancy related services.**		X
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, PROVIDE FIRST DATE – Enter date in MMDDYY format. Optional.		X
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** – If Field 10a is Yes, enter the applicable FROM and TO dates in a MMDDYY format. **Required, if applicable.**		X
17	**NAME OF REFERRING PHYSICIAN OR OTHER SOURCE** – Enter the name of the referring physician For waiver related services, enter the provider name of the case manager. **Required for *Medicaid Select* PMP.** *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** – Enter the IHCP provider number of the restricted provider for restricted members, provider number of the case manager for waiver members, provider number of the *Medicaid Select* primary medical provider (PMP). **Required for these members.**		X

(Continued)

Table 2 – CMS-1500 Claim Form Locator

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** – Enter the requested FROM and TO dates in MMDDYY format (CCYYMMDD if submitting electronically). **Required, if applicable.**		X
19	**RESERVED FOR LOCAL USE** – Use the *Medicaid Select* PMP two-digit alphanumeric certification code. **Required for *Medicaid Select* members when the physician rendering care is not the PMP or a member of the PMP's group or clinic enrolled with the same billing number as the PMP.**		X
20	OUTSIDE LAB? – Enter **X** in 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/or 21.4 to Field 24e by detail line. Enter the *ICD-9-CM* diagnosis codes in priority order. A total of four codes can be entered. At least one diagnosis code is required for all claims except those 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. – Applicable for Medicare Part B Crossover claims only. For crossover claims, the combined total of the Medicare coinsurance, deductible, and psych reduction must be reported on the left 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 side under the heading *Original Ref No.*		X
23	PRIOR AUTHORIZATION NUMBER – The prior authorization (PA) number is not required, but entry is recommended to assist in tracking 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.*			
24A	**DATE OF SERVICE** – Enter the FROM and TO dates in MMDDYY format. Up to six FROM and TO dates are allowed per form. **FROM and TO dates must be the same – no date ranges are allowed. 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/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf or Table 8.22 in the* IHCP Provider Manual.	X	
24C	Type of Service – Not applicable.		X
24D	**PROCEDURES, SERVICES, OR SUPPLIES**	X	
	CPT/HCPCS – Enter the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line. **Required.**	X	
	MODIFIER – Enter the appropriate modifier, if applicable. Up to four modifiers are allowed for each procedure code. **Required, if applicable.**	X	

(Continued)

Table 2 – CMS-1500 Claim Form Locator

Form Locator	Narrative Description/Explanation	Complete for MRT	
		Yes	No
24E	**DIAGNOSIS CODE** – Enter number 1 - 4 corresponding to the applicable diagnosis codes in Field 21. A minimum of one and a maximum of four diagnosis code references are allowed on each line. **Required.**		X
24F	**$ CHARGES** – Enter 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 numeric field. **Required.**	X	
24G	**DAYS OR UNITS** – Enter 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, enter a **P** in this field on each applicable line. **Required, if applicable.**		X
24I	**EMG** – Emergency indicator. Enter **Y** or **N**. **Required, if applicable.**		X
24J	COB - Providers who bill for early and periodic screening, diagnosis, and treatment (EPSDT) services using the paper CMS-1500 claim forms should use a value of **Y** in Field 24J in the coordination of benefits (COB) field at the service line.		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. Enter the individual or rendering provider number in Field 24K. Enter the group provider number in Field 33 as the billing provider number. *Providers **not** associated with a group should enter the unique, individual provider number, including the location code in Field 33.*			
24K	**RESERVED FOR LOCAL USE** – Enter the rendering provider number of the group member, or the sole proprietor number using the entire nine-digit number, 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. – Enter the internal patient tracking number. Optional.	X	
27	ACCEPT ASSIGNMENT? – The IHCP provider agreement includes details about accepting payment for services. Optional.		X
28	**TOTAL CHARGE** – Enter the total of column 24F. This is an eight-digit field. **Required.**	X	
29	**AMOUNT PAID** – Enter payment amounts received from any other source excluding the 8A deductible and the Medicare Paid Amount. All applicable items are combined and the total entered here. **Required, if applicable.** Other insurance – Enter the amount paid by the other insurer. If the other insurer was billed but paid zero, enter **0** in this field. Attach denials to the claim form when submitting. Spend-down members – Attach the *DPW Form 8A* to the claim form when submitting for claim adjudication. No deductible amount is entered in this field.	X	
30	**BALANCE DUE** – Field 28, TOTAL CHARGE - Field 29, AMOUNT PAID - Field 30, BALANCE DUE. **Required.**	X	

(Continued)

Table 2 – CMS-1500 Claim Form Locator

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. Providers who have signed the certification form attached to bulletin *BT200103* will have their claims processed when a signature is omitted from this field. **Required.** **DATE –** Enter the date the claim was filed. **Required.**	X	
32	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED, if other than home or office - enter 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. Enter the rendering provider number of the group member or sole proprietor number in Field 24K. Enter the billing number for the group in Field 33 as the billing provider number. *Providers not associated with a group should enter the unique, individual provider number, including location code, in Fields 24K and 33.*	X	
33	**PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE #** – Enter the billing provider number, nine-digit numerical, and location code, one alpha character. **Required.**	X	

Changes Corresponding to the HIPAA-Required 837P Transaction

Place of service codes are available from the Centers for Medicare & Medicaid Services Web site at http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf. Table 3 is taken directly from this source.

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	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

(Continued)

Table 3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name	Place of Service Description
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients
09	Prison-Correctional Facility***	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06)
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home*	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

(Continued)

Table 3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name	Place of Service Description
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

(Continued)

Table 3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name	Place of Service Description
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A

(Continued)

Table 3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name	Place of Service Description
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician. (effective 10/1/03)
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.