IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201353 NOVEMBER 5, 2013

The IHCP to transition to the new version of the *CMS-1500* paper claim form

The information in this bulletin supersedes information previously communicated through bulletins, banner pages, or workshop training materials. The following information does not apply to providers rendering services in the risk-based managed care (RBMC) delivery system. RBMC providers should contact the managed care entity (MCE) with which they are contracted for information about transitioning to the new CMS-1500 paper claim form.

Based on recommendations of the National Uniform Claim Committee (NUCC), the Centers for Medicare & Medicaid Services (CMS) is mandating use of the revised *CMS-1500* claim form. Effective April 1, 2014, the Indiana Health Coverage Programs (IHCP) will accept only the revised version of the *CMS-1500* (02/12) paper claim form. Paper claims submitted on the current version of the *CMS-1500* (08/05) after March 31, 2014, will not be processed and will be returned to the provider. Both current and revised forms will be accepted during a transition period from January 6, 2014, through March 31, 2014. The effective dates for transition to the new form are based on date of claim submission rather than date of service.

Table 1 - Time line for transitioning to the revised CMS-1500 paper claim form

		Transition Period (Current and Revised Forms Accepted)		Only Revised Forms Accepted
Current Form	**Revised Form**	**Start Date**	**End Date**	**(Cutover Date)**
CMS-1500 (08-05)	*CMS-1500* (02/12)	January 6, 2014	March 31, 2014	April 1, 2014

The revised *CMS-1500* (02/12) claim form includes the following changes:

- Additional fields for up to 12 diagnosis codes
- Increased field length for the ICD diagnosis code for up to seven characters with no decimal point
- An ICD indicator (to reflect ICD-9 or ICD-10 code set)
- Accommodations for up to four related diagnosis code references, with letters A-L corresponding to the applicable diagnosis codes in fields 21 A-L

CMS-1500 (02/12) claim form instructions

The instructions outlined in this bulletin are effective for paper claim submissions on the revised *CMS-1500* (02/12) claim form. A sample of the new claim form is included in this bulletin for reference.

Note that some form fields are required while others are optional. Table 2 describes each claim form field and uses **bold** type to indicate if a field is "**required"** or "**required, if applicable."** Fields that are "optional" and "not applicable" are displayed in normal type. Instructions applicable to particular provider types are included. The table describes each form locator by referring to the number found in the left corner of each box on the *CMS-1500* (02/12) claim form. All form locator fields with changes are noted with asterisks (*).

These instructions apply to the IHCP guidelines only and are not intended to replace instructions issued by the NUCC. The NUCC instruction manual can be found at nucc.org.

Table 2 - CMS-1500 (02/12) *claim form field descriptions*

Form Locator	Narrative Description/Explanation
1	**INSURANCE CARRIER SELECTION** – Enter **X** for Traditional Medicaid. **Required**.
1a	**INSURED'S I.D. NUMBER** (FOR PROGRAM IN ITEM 1) – Enter the IHCP member identification number (RID). Must be 12 digits. **Required**.
2	**PATIENT'S NAME** (Last Name, First Name, Middle Initial) – Enter 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**.
3	PATIENT'S BIRTH DATE – Enter the member's birth date in MMDDYY format. Optional. SEX – Enter **X** in the appropriate box. Optional.
4	INSURED'S NAME (Last Name, First Name, Middle Initial) – Not applicable.
5	PATIENT'S ADDRESS (No., Street), city, state, ZIP Code, telephone (include area code) – Enter the member's complete address information. Optional.
6	PATIENT RELATIONSHIP TO INSURED – Not applicable.
7	INSURED'S ADDRESS (No., Street), city, state, ZIP Code, telephone (include area code) – Not applicable.
8*	RESERVED FOR NUCC USE – Not applicable.
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, enter the policyholder's name. **Required, if applicable**.

Table 2 - CMS-1500 (02/12) claim form field descriptions (Continued)

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**.
9b*	RESERVED FOR NUCC USE – Not applicable.
9c*	RESERVED FOR NUCC USE – Not applicable.
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, enter the policyholder's insurance plan name or program name information. **Required, if applicable**.
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**.
10a	**EMPLOYMENT** (CURRENT OR PREVIOUS) – Enter **X** in the appropriate box. **Required, if applicable**.
10b	**AUTO ACCIDENT** – Enter **X** in the appropriate box. **Required, if applicable**. **PLACE (State)** – Enter the two-character state code. **Required, if applicable**.
10c	**OTHER ACCIDENT** – Enter **X** in the appropriate box. **Required, if applicable**.
10d*	CLAIM CODES (Designated by NUCC) – Not applicable
Fields 11 and 11a through 11d are used to enter member insurance information.	
11	**INSURED'S POLICY GROUP OR FECA NUMBER** – Enter the member's policy and group number of the other insurance. **Required, if applicable**.
11a	**INSURED'S DATE OF BIRTH** – Enter the member's birth date in MMDDYY format. **Required, if applicable**. **SEX** – Enter **X** in the appropriate sex box. **Required, if applicable**.
11b*	OTHER CLAIM ID (Designated by NUCC) – Not applicable
11c	**INSURANCE PLAN NAME OR PROGRAM NAME** – Enter the member's insurance plan name or program name. **Required, if applicable**.
11d*	**IS THERE ANOTHER HEALTH BENEFIT PLAN?** – Enter **X** in the appropriate box. If the response is *Yes*, complete fields 9, 9a, and 9d. **Required, if applicable**.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – Not applicable.
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – Not applicable.
14*	**DATE OF CURRENT ILLNESS** (First symptom date) **OR INJURY** (Accident date) **OR PREGNANCY** (LMP date) – Enter the date of the last menstrual period (LMP) for pregnancy-related services in MMDDYY format. **Required, if applicable**. *Note: Qualifier Code is not applicable.*
15*	OTHER DATE – Enter date in MMDDYY format. Optional. *Note: Qualifier Code is not applicable.*
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**.
17*	**NAME OF REFERRING PROVIDER OR OTHER SOURCE** – Enter the name of the referring physician. **Required, if applicable.** For waiver-related services, enter the provider or the case manager name. Optional. *Note: Qualifier Code is not applicable. The term referring provider includes physicians primarily responsible for the authorization of treatment for lock-in or Right Choices Program members.*

Table 2 - CMS-1500 (02/12) claim form field descriptions (Continued)

17a	**ID NUMBER OF REFERRING PROVIDER, ORDERING PROVIDER, OR OTHER SOURCE** – Enter the qualifier in the first shaded box of 17a, indicating what the number reported in the second shaded box of 17a represents. Atypical providers should report the IHCP LPI provider number in the second box of 17a. Healthcare providers should report the taxonomy code in the second box of 17a. The qualifier is required when entering the IHCP LPI provider number or taxonomy. Qualifiers to report to IHCP: • **1D** and **G2** are the qualifiers that apply to the IHCP provider number, also called the LPI for the atypical nonhealthcare provider. The LPI includes nine numeric characters and one alpha character for the service location. • **ZZ and PXC** are the qualifiers that apply to the provider taxonomy code. The taxonomy code includes 10 alphanumeric characters. Taxonomy may be needed to establish a one-to-one NPI/LPI match if the provider has multiple locations. Required when applicable and for any waiver-related services. **Required, if applicable**.
17b	**NPI** – Enter the 10-digit numeric NPI of the referring provider, ordering provider, or other source. **Required, if applicable**.
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** – Enter the requested FROM and TO dates in MMDDYY format. **Required, if applicable.**
19*	ADDITIONAL CLAIM INFORMATION (Designated by NUCC) – Not applicable.
20	OUTSIDE LAB? – Not applicable. CHARGES – Not applicable.
21* A-L	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY –** Complete fields 21A-L through field 24E by detail line. Enter the ICD diagnosis codes in priority order. A total of 12 codes can be entered. **Required**.
ICD Ind.	**ICD Ind**. – Enter **9** to indicate the diagnosis codes in fields 21 A-L are ICD-9 diagnosis codes. Enter **0** to indicate the diagnosis codes in fields 21A-L are ICD-10 diagnosis codes. **Required.**
22*	**RESUBMISSION CODE, ORIGINAL REF. NO.** – Applicable for Medicare Part B crossover claims and Medicare Replacement Plan claims. For crossover claims, the combined total of the Medicare coinsurance, deductible, and psychiatric 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*. **Required, if applicable**.
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.
Note:	*Date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. For services requiring prior authorization, the FROM date of service cannot be prior to the dates for which the service was authorized. The TO date of service cannot exceed the dates for which the service was authorized*
24A to 24I Top Half – Shaded Area	**NATIONAL DRUG CODE INFORMATION –** The shaded portion of fields 24A to 24I is used to report NDC information. **Required as of August 1, 2007**. To report this information, begin at field 24A as follows: 1. Enter the NDC qualifier of N4. 2. Enter the NDC 11-digit numeric code. 3. Enter the drug description. 4. Enter the NDC Unit qualifier: F2 – International Unit GR – Gram ML – Milliliter UN – Unit 5. Enter the NDC Quantity (Administered Amount) in the format 9999.99.

Table 2 - CMS-1500 (02/12) claim form field descriptions (Continued)

24A* Bottom Half	**DATE(S) OF SERVICE** – Provide the FROM and TO dates in MMDDYY format. Up to six FROM and TO dates are allowed per form. **Required**.
24B	**PLACE OF SERVICE** – Use the POS code for the facility where services were rendered. For a list of POS codes, go to the *Place of Service Codes Overview* page on the CMS website at cms.hhs.gov. **Required**.
24C	**EMG** – Emergency indicator. This field indicates services were for emergency care for service lines with a CPT or HCPCS code in field 24D. Enter **Y** or **N**. **Required, if applicable**.
24D	**PROCEDURES, SERVICES, OR SUPPLIES** **CPT/HCPCS** – Use the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line. **Required**. **MODIFIER** – Use the appropriate modifier, if applicable. Up to four modifiers are allowed for each procedure code. **Required, if applicable**.
24E*	**DIAGNOSIS POINTER –** Enter letter A-L corresponding to the applicable diagnosis codes in field 21. A minimum of one and a maximum of four diagnosis code references can be entered on each line. **Required**. *Note: The alpha value of A-L entered for the diagnosis pointer will be systematically converted to match the Electronic Data Interchange (EDI) value of 1-12 as depicted below:*
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 a 10-digit field. **Required**.
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**.
24H	**EPSDT Family Plan** – If the patient is pregnant, indicate with a **P** in this field on each applicable line. **Required, if applicable**.
24I Top Half – Shaded Area	**RENDERING ID QUALIFIER –** Enter the *qualifier* indicating what the number reported in the shaded area of 24J represents – 1D or G2 for IHCP LPI rendering provider number or ZZ or PXC for rendering provider taxonomy code. **Required, if applicable**. • **1D** and **G2** are the qualifiers that apply to the IHCP provider number (LPI) for atypical nonhealthcare providers. The LPI includes nine numeric characters. **Atypical providers (for example, certain transportation and waiver service providers) are required to submit their LPIs.** • **ZZ and PXC** are the qualifiers that apply to the provider taxonomy code. The taxonomy code includes 10 alphanumeric characters. The taxonomy code may be required for a one-to-one match.
24J Top Half – Shaded Area	**RENDERING PROVIDER ID** – Enter the LPI if entering the 1D or G2 qualifier in 24I or the taxonomy if entering the ZZ or PXC qualifier in 24I for the Rendering Provider ID or G2. **Required, if applicable**. • **LPI** – The entire nine-digit LPI must be used. If billing for case management, the case manager's number must be entered here. • **Taxonomy** – Enter the taxonomy code of the rendering provider. Optional unless required for a one-to-one match.
24J Bottom Half	**RENDERING PROVIDER NPI** – Enter the NPI of the rendering provider. **Required if applicable**.
25	FEDERAL TAX I.D. NUMBER – Not applicable.

A	B	C	D	E	F	G	H	I	J	K	L
1_	2_	3_	4_	5_	6_	7_	8_	9_	10	11	12

Table 2 - CMS-1500 (02/12) claim form field descriptions (Continued)

26	PATIENT'S ACCOUNT NO. – Enter the internal patient tracking number. Optional.
27	ACCEPT ASSIGNMENT? – The *IHCP Provider Agreement* includes details about accepting payment for services. Optional.
28	**TOTAL CHARGE** – Enter the total of all service line charges in column 24F. This is a 10-digit field, such as 99999999.99. **Required**.
29	**AMOUNT PAID** – Enter the payment received from any other source, excluding the traditional Medicare or Medicare Replacement Plan paid amount. All applicable items are combined and the total entered in this field. This is a 10-digit field. **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 the claim for adjudication.
30*	RESERVED FOR NUCC USE – Not applicable.
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 that have signed the *Claims Certification Statement for Signature on File* form will have their claims processed when a signature is omitted from this field. This form is available on the *Forms* page on indianamedicaid.com. **Required if applicable**. **DATE** – Enter the date the claim was filed. **Required**.
32	SERVICE FACILITY LOCATION INFORMATION – Enter the provider's name and address where the services were rendered, if other than home or office. This field is optional, but it helps HP contact the provider, if necessary. Optional.
32a	SERVICE FACILITY LOCATION NPI – Not applicable.
32b	SERVICE FACILITY LOCATION QUALIFIER AND ID NUMBER – Not applicable.
33	**BILLING PROVIDER INFO & PH #** – Enter the provider service location name, address, and the ZIP Code+4 as listed on the provider enrollment profile. **Required**. *Note: If the U.S. Postal Service provides an expanded ZIP Code (ZIP Code + 4) for a geographic area, this expanded ZIP Code must be entered on the claim form.*
33a	**BILLING PROVIDER NPI** – Enter the billing provider NPI. **Required**.
33b	**BILLING PROVIDER QUALIFIER AND ID NUMBER –** Healthcare providers may enter a billing provider qualifier of ZZ or PXC and taxonomy code. Taxonomy may be needed to establish a one-to-one NPI/LPI match if the provider has multiple locations. If the billing provider is an atypical provider, enter the qualifier 1D or G2 and the LPI. **Required**.

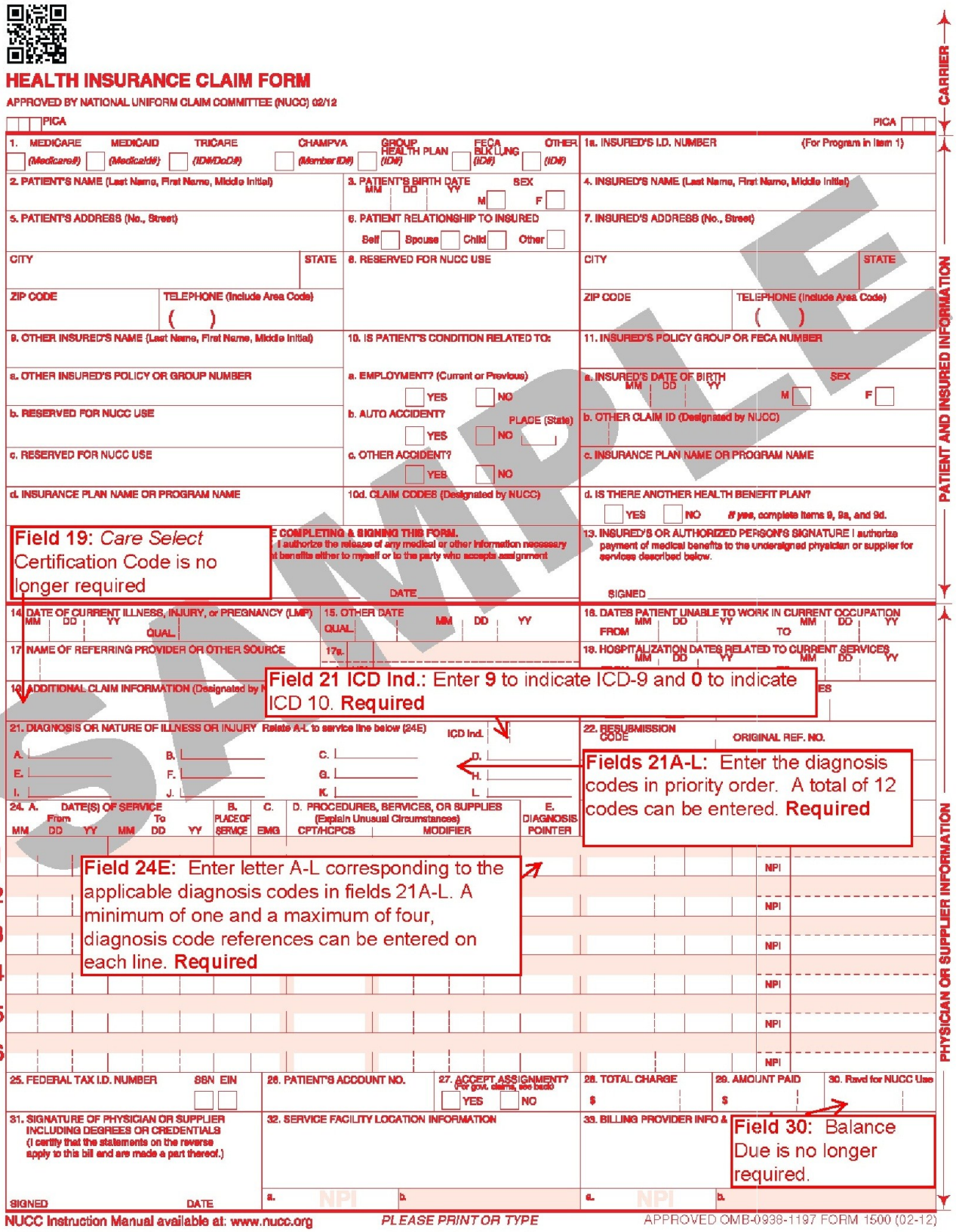
Field 19 – Certification Codes

Care Select discontinued the use of the certification codes for all claims with dates of service on or after January 1, 2011. Providers were no longer required to submit the certification code in field 19 for dates of service on or after January 1, 2011. As of January 6, 2014, certification codes are no longer a requirement regardless of the date of service. Therefore, the following edits will be deactivated:

- Edit 1047 − *The certification code is missing - Care Select. Please verify and resubmit.*
- Edit 1048 − *The certification code is invalid - Care Select. Please verify and resubmit.*

The certification code field will be removed from all Professional Claim pages on Web interChange and will no longer be accepted via the Electronic Data Interchange (EDI) 837 P (Professional) transactions. Covered services under Care Select will remain the same, and HP continues to be the processor of Care Select claims.

Revised *1500* Health Insurance Claim Form



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