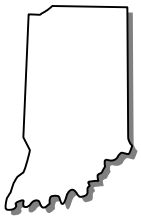
Indiana Health Coverage Programs



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

B T 2 0 0 3 6 4 S E P T E M B E R 3 0 , 2 0 0 3

To: All Providers

Subject: Updated Paper Claim Form Requirements and Paper Attachment Instructions for All Claim Types and HIPAA Implementation Updates

Overview

The Indiana Health Coverage Programs (IHCP) revised the paper claim form billing instructions to align the paper claim process with the electronic claim requirements mandated by the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification requirements. This bulletin describes the changes to claim submission instructions due to HIPAA requirements. Providers should refer to the appropriate implementation guide and IHCP companion guide for information about specific electronic transactions.

> *Note: The information in this bulletin supersedes information that has been previously communicated through bulletins, banner pages, or workshop training materials.*

These instructions are effective for paper claim submission starting November 14, 2003. Paper claims with a postmark date of November 14, 2003, and after must meet the new claim form requirements. Non-compliant paper claims submitted November 14, 2003, and after, will deny.

This bulletin contains the following information:

- Paper claim requirements
- Centers for Medicare and Medicaid Services (CMS)-1500 claim form requirements
- UB-92 claim form requirements
- American Dental Association (ADA), 1999 version 2000 claim form requirements
- Paper attachment requirements

Paper Claim Requirements

This section describes revisions to paper claim submission requirements that are applicable to more than one claim type. These changes are required to bring paper claim requirements into compliance with the new HIPAA electronic claim transaction requirements.

Modifiers

Four modifiers per procedure code will be accepted on the CMS-1500 and UB-92 claim forms for claims submitted November 14, 2003, and after. There are currently no modifiers approved for use with the CDT-4 code set on the dental claim form.

Local Code Elimination

Healthcare Common Procedure Coding System (HCPCS) level III procedure codes, referred to as local codes, are eliminated for claims submitted for dates of service on or after January 1, 2004. Local modifiers are also end dated for the same dates of service with the exception of anesthesia modifiers W5, W6, and W7. Modifiers W5, W6, and W7 will be eliminated for dates of service effective October 16, 2003, and after. All other local codes used by the IHCP will be end dated December 31, 2003. These codes have been cross walked to one of the following:

- A Current Procedural Terminology (CPT) level one or HCPCS level II procedure code
- A CPT or HCPCS procedure code plus modifier
- A CPT or HCPCS procedure code plus taxonomy code

This crosswalk was necessary for appropriate provider payment. Reimbursement changes were not made because of the local code elimination. See IHCP provider bulletin *BT200353* for specific details about the local code crosswalk. Some crosswalk time requirements have changed due to new procedure code definitions. See the local code updates information at the end of this bulletin for more information about this.

National Drug Code Billing

The IHCP is currently evaluating whether national drug code (NDC) information will be required for the 837I and 837P electronic transactions, as well as the UB-92 and CMS-1500 paper claim form submission. Currently, non-pharmacy providers are not required to provide NDC information when submitting claims to the IHCP.

Procedure Code Partial Units

Partial units are allowed on the ADA 2000 and CMS-1500 claim forms for procedure codes that accommodate fractional units. CPT and HCPCS codes can only be submitted on the UB-92 claim form using whole units.

Each procedure code quantity allows for two decimal places when submitting partial units. Examples of procedure codes using partial units are listed in Table 1.

Table 1 – Partial Units Procedure Code Billing Examples

Procedure Code and Usage	Partial Unit Quantity Example
A4927 – Gloves, nonsterile, per 100 (two gloves used)	A4927 – 0.02 units
G0108 – Diabetes outpatient self-management training services, individual, per 30 minutes (15 minute training service session)	G0108 – 0.50 units

Note: Procedure code G0108 will be effective January 1, 2004, and after.

CMS-1500 Claim Form Requirements

Anesthesia Services

The Administrative Simplification requirements of HIPAA mandate adopting the standards for the anesthesia CPT codes. Effective October 16, 2003, and after, providers submitting anesthesia services must use the anesthesia CPT codes 00100 through 01999. Anesthesia charges must be submitted using the anesthesia CPT code that corresponds to the surgical procedure performed. Refer to IHCP provider bulletin *BT200353* for specific details about the modified anesthesia billing requirements.

Pregnancy-Related Services

The last menstrual period (LMP) date is required for submission of pregnancy-related services effective November 14, 2003. Currently, the IHCP requires the estimated due date (EDD) for determination of member pregnancy status and trimester information used to ensure timely and appropriate antepartum care. The LMP information is provided in field 14, in MMDDYY format.

IHCP provider bulletin *BT200353* describes trimester modifier changes due to the elimination of local codes and modifiers.

CMS-1500 Claim Form Changes

This section provides a brief overview of the changes required for completion of the CMS-1500 claim form. These instructions revise the April 2003 *IHCP Provider Manual* instructions and any provider bulletins referenced in this section.

The CMS-1500 form completion modifications are changes that correspond to the 837P electronic claim transaction and clarifications to the CMS-1500 claim form. All data elements submitted may not be used for claim processing; however, they may be required for 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 effective November 14, 2003, and after. The changes noted below are for affected form locator fields:

Changes Corresponding to the HIPAA-Required 837P Transaction

- Field 14 *Date of Current: Illness (First symptom) OR Injury (Accident) OR Pregnancy (LMP)* – Use the LMP date instead of the EDD for pregnancy related services. (Required, if applicable)

- Field 24B *Place of Service* –Additional place of service (POS) codes are available. A complete listing of POS codes can be found at http://cms.hhs.gov/states/poshome.asp and in Table 2 below. (Required)

Table 2 – 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
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

(Continued)

Table 2 – Place of Service Codes

Place of Service Code(s)	Place of Service Name
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

* New Place of Service Code, effective September 26, 2003.
** Revised Place of Service code, effective September 26, 2003.

- Field 24D *Modifier* – Four modifiers per procedure code are allowed. (Required, if applicable)
- Field 24G *Days or Units* – Partial units are allowed if appropriate for the procedure code. Each procedure code quantity allows for six digits including two decimal places, such as 9999.99. (Required)

Clarification of the CMS-1500 Claim Form

- Field 2 *Patient's Name* – In addition to the current methods, providers can verify IHCP member information through the Web interChange.

All form locator fields with a change are noted with an asterisk (*) in Table 3 below.

CMS-1500 Claim Form Fields

This section explains completion of the CMS-1500 claim form. Some information is required to complete the claim form, while other information is optional.

Table 3 indicates in bold type if a field is required or required, if applicable. Optional information is displayed in normal type. Specific instructions applicable to a particular provider type are noted as well. The instructions describe each form locator by referring to the number found in the left corner of each box on the CMS-1500 claim form. These boxes contain the data elements.

Indiana*AIM* can process a maximum of six service lines per paper CMS-1500 claim form.

Table 3 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
1	**INSURANCE CARRIER SELECTION** – Mark Traditional Medicaid. **Required**.
1a	**INSURED'S I.D. NUMBER** (FOR PROGRAM IN ITEM 1) – Provide the member identification (RID) number. Must be 12 digits. **Required.**
2*	**PATIENT'S NAME** (Last Name, First Name, Middle Initial) – Provide the member's last name, first name, and middle initial obtained from automated voice response (AVR) system, electronic claim submission (ECS), OMNI, or Web interChange verification. **Required**.

(Continued)

Table 3 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
3	PATIENT'S BIRTH DATE – Provide the member's birth date in MMDDYY format. Optional. SEX – Mark the appropriate box. Optional.
4	INSURED'S NAME (Last Name, First Name, Middle Initial) – Not applicable. The IHCP member is always the insured.
5	PATIENT'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE (include Area Code) – Provide 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	PATIENT STATUS – Mark the appropriate box. Optional.
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.	
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.**
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**.
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.
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**.
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.**
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**.
10a	**EMPLOYMENT?** (CURRENT OR PREVIOUS) – Mark **Yes** or **No**. **Required, if applicable**.
10b	**AUTO ACCIDENT?** – Mark **Yes** or **No**. **Required, if applicable**. **PLACE (State)** – Use the two-character state code. **Required, if applicable**.
10c	**OTHER ACCIDENT?** – Mark **Yes** or **No**. **Required, if applicable**.
10d	RESERVED FOR LOCAL USE – Not applicable.
Fields 11 and 11a through 11c provide member insurance information.	
11	**INSURED'S POLICY GROUP OR FECA NUMBER** – Provide the member's policy and group number of the other insurance. **Required, if applicable**.

(Continued)

Table 3 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
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**.
11b	**EMPLOYER'S NAME OR SCHOOL NAME** – Provide the requested member information**. Required, if applicable.**
11c	**INSURANCE PLAN NAME OR PROGRAM NAME** – Provide the member's insurance plan name or program name. **Required, if applicable.**
11d	**IS THERE ANOTHER HEALTH BENEFIT PLAN?** Mark **Yes** or **No**. If the response is *Yes*, complete Fields 9a–9d**. Required, if applicable**.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – Use this field for Claim Note Text. Enter any information, up to 60 characters, that may be helpful in further describing the billed service. 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.
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) – Use the date of the last menstrual period for pregnancy related services in MMDDYY format. **Required, if applicable.**
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, PROVIDE FIRST DATE – Not applicable.
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**.
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 Prime*Step* (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.
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 Prime*Step* (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.
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** – Provide the requested FROM and TO dates in MMDDYY format. **Required, if applicable**.
19	**RESERVED FOR LOCAL USE** – Use the Hoosier Healthwise or *Medicaid Select* PMP two-digit alphanumeric certification code. **Required for Prime*Step* PCCM members**.
20	OUTSIDE LAB? – Mark the appropriate box. Optional. $CHARGES – Eight-digit numeric field. Optional.
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**.

(Continued)

Table 3 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
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*.
23	PRIOR AUTHORIZATION NUMBER – The prior authorization (PA) number is not required, but use is recommended to track services that require PA. Optional.
Date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. • *For services requiring PA, 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 spend-down members, dates of service prior to the spend-down effective date are not eligible for reimbursement, because the patient is not yet eligible for services.* *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.* • *For DME monthly rentals, the start date for the billing cycle is both the FROM and TO date.*	
24A	**DATE OF SERVICE** – Provide the FROM and TO dates in MMDDYY format. Up to six date ranges are allowed per form. **Required**.
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 2 above.*
24C	Type of Service – Not 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 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.**
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.**

(Continued)

Table 3 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
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	**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.**
24J	COB – Not Applicable
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.**
25	FEDERAL TAX I.D. NUMBER – Not applicable.
26	PATIENT'S ACCOUNT NO. – Provide the internal patient tracking number. Optional.
27	ACCEPT ASSIGNMENT? – The IHCP provider agreement includes details about accepting payment for services. Optional.
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.**
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.
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.**
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.**
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.

(Continued)

Table 3 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
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.*	
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.**

UB-92 Claim Form Requirements

UB-92 Claim Form Changes

This section provides a brief overview of the changes required for completion of the UB-92 claim form. These instructions revise the April 2003 *IHCP Provider Manual* instructions and any provider bulletins referenced in this section. The form completion modifications are changes that correspond to the 837I electronic claim transaction and clarifications to the UB-92 claim form. Each field indicates if the field is required, required if applicable, optional, or not applicable, effective November 14, 2003. The changes noted below are for the affected form locator fields:

Changes Corresponding to the HIPAA-Required 837I Transaction

- Field 4 *Type of Bill* – The IHCP will accept all type of bill codes that are not used for claims processing. Type of bill codes can be found at www.indianamedicaid.com. (Required)
- Field 22 *Stat* –Additional *Status* codes are provided in Table 4. (Required for inpatient and LTC)
- Field 44 *HCPCS/RATES* – This field is also used to identify procedure code modifiers. Provide the appropriate modifier, as applicable. Up to four modifiers are allowed for each procedure code. This is an eight-character field. Required, if applicable.
- Field 46 *Serv. Units* – Six digits are now allowed in this field including two decimal places, such as 9999.99. Procedure codes and revenue codes must be billed using whole numbers. (Required)

Clarification of the UB-92 Claim Form

- Fields 39a-41d *Value Codes* – *Value Codes A1*, *A2*, and *06* are required as indicated in the IHCP provider bulletin *BT200245*. This information is a revision to the April 2003 *IHCP Provider Manual*.
- Field 45 *Serv. Date* – Also required for independent laboratories and dialysis providers. (Required for applicable providers)
- Field 54a-54c *Prior Payments* – The Medicare Remittance Notice (MRN), formerly known as Explanation of Medicare Benefits (EOMB), is no longer required if Medicare makes a payment. This information was previously published in the IHCP provider bulletin *BT200245* and is a revision to the April 2003 *IHCP Provider Manual*.

- Field 67 *Prin. Diag. Cd*. – Also required for Ambulatory Surgery Center (ASC) claims. (Required for applicable providers)
- Fields 68-75 *Other Diag. Codes* – Also required for ASC claims, if applicable. (Required for applicable providers)
- Field 77 *E-Code* – The E code is the ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.
- Field 80 Principal Procedure Code/Date – Use this field for inpatient procedures, when appropriate. (Required, when applicable)
- Field 81 *Other Procedure Code/Date* – Use this field for inpatient procedures, when appropriate. (Required, when applicable)
- Field 83A *Other Phys. ID* – Use this field to provide the license number of the physician performing the principal procedure. (Required for inpatient procedures)
- Field 84 Remarks – Use this field for *Claim Note Text*. Provide any information, up to 80 characters, that further describes the services rendered. The *Claim Note Text* field is not data entered into Indiana*AIM*; however, the Claim Resolution Unit may use the text for suspended claim processing. (Optional)

All form locator fields with a change are noted with an asterisk (*) in Table 4.

UB-92 Claim Form Fields

This section provides instructions for completing the UB-92 claim form. Basic information about UB-92 claim form locators is provided in the chart. Specific directions applicable to a particular provider type are noted when necessary.

The form locator chart indicates, in bold type, fields that are required or required, if applicable. The following instructions describe each form locator, or data element, by referring to the number in the left corner of each box on the UB-92 claim form.

Providers must use the UB-92 billing manual conventions unless otherwise specified. Table 4 provides IHCP specific field information for the UB-92 claim form.

Indiana*AIM* can process a maximum of 23 service lines per paper UB-92 claim form.

Table 4 – UB-92 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
1	**PLEASE REMIT PAYMENT TO** – Use the provider's name, address, and telephone number. **Required.**
2	UNLABELED FIELD – Not applicable.
3	**PATIENT CONTROL NO.** – Provide the internal patient tracking/account number. **Required.**

(Continued)

Table 4 – UB-92 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
4*	**TYPE OF BILL** – Use the code indicating the specific type of bill. This three-digit code requires one digit from each of the following categories in the following sequence; all positions must be fully coded. **Required**. First position – Type of facility Second position – Bill classification Third position – Frequency *Note: See www.indianamedicaid.com for a listing of Type of Bill codes current for this date. Because this code set is maintained by the National Uniform Billing Committee (NUBC) and is considered an external code set by the HIPAA requirements, the IHCP is not responsible for updating the type of bill code(s) set. It is the provider's responsibility to monitor the changes made to this external code set.*
5	FED. TAX NO. – Not applicable.
6	**STATEMENT COVERS PERIOD, FROM/THROUGH** – Provide the beginning and ending service dates. For all services rendered on a single day, use both the FROM and THROUGH dates. Indicate dates in MMDDYY format, such as 122502. **Required for inpatient and LTC.**
7	**COV D.** – Provide the number of days for the STATEMENT COVERS PERIOD. **Required for inpatient and LTC.**
8	N-CD – Not applicable.
9	C-I D. – Not applicable.
10	L-R D. – Not applicable.
11	UNLABELED FIELD – Not applicable.
12	**PATIENT NAME** – Provide the last name, first name, and middle initial of the member**. Required**.
13	PATIENT ADDRESS – Provide the member's full mailing address. Optional.
14	BIRTHDATE – Provide the member's birth date in a MMDDYY format. Optional.
15	SEX – Provide the member's sex. Optional.
16	MS – Provider the member's marital status. Optional.
17	**ADMISSION DATE** – Provide the date the patient was admitted for inpatient care in a MMDDYY format. **Required for inpatient and LTC.**
18	**ADMISSION HOUR** – Indicate the Admission Hour code for the timeframe the patient was admitted for inpatient care**. Required for inpatient**.

(Continued)

Table 4 – UB-92 Claim Form Locator Descriptions

<table>
<tr><th>Form Locator</th><th colspan="4">Narrative Description/Explanation</th></tr>
<tr><td rowspan="15"></td><td colspan="4">Admission Hour Code Structure</td></tr>
<tr><td>Code</td><td>Timeframe a.m.</td><td>Code</td><td>Timeframe p.m.</td></tr>
<tr><td>00</td><td>12:00 a.m. midnight – 12:59 a.m.</td><td>12</td><td>12:00 p.m. noon – 12:59 p.m.</td></tr>
<tr><td>01</td><td>01:00 a.m. – 01:59 a.m.</td><td>13</td><td>01:00 p.m. – 01:59 p.m.</td></tr>
<tr><td>02</td><td>02:00 a.m. – 02:59 a.m.</td><td>14</td><td>02:00 p.m. – 02:59 p.m.</td></tr>
<tr><td>03</td><td>03:00 a.m. – 03:59 a.m.</td><td>15</td><td>03:00 p.m. – 03:59 p.m.</td></tr>
<tr><td>04</td><td>04:00 a.m. – 04:59 a.m.</td><td>16</td><td>04:00 p.m. – 04:59 p.m.</td></tr>
<tr><td>05</td><td>05:00 a.m. – 05:59 a.m.</td><td>17</td><td>05:00 p.m. – 05:59 p.m.</td></tr>
<tr><td>06</td><td>06:00 a.m. – 06:59 a.m.</td><td>18</td><td>06:00 p.m. – 06:59 p.m.</td></tr>
<tr><td>07</td><td>07:00 a.m. – 07:59 a.m.</td><td>19</td><td>07:00 p.m. – 07:59 p.m.</td></tr>
<tr><td>08</td><td>08:00 a.m. – 08:59 a.m.</td><td>20</td><td>08:00 p.m. – 08:59 p.m.</td></tr>
<tr><td>09</td><td>09:00 a.m. – 09:59 a.m.</td><td>21</td><td>09:00 p.m. – 09:59 p.m.</td></tr>
<tr><td>10</td><td>10:00 a.m. – 10:59 a.m.</td><td>22</td><td>10:00 p.m. – 10:59 p.m.</td></tr>
<tr><td>11</td><td>11:00 a.m. – 11:59 a.m.</td><td>23</td><td>11:00 p.m. – 11:59 p.m.</td></tr>
<tr><td></td><td></td><td>99</td><td>Hour unknown</td></tr>
<tr><td rowspan="6">19</td><td colspan="4">ADMISSION TYPE – Provide the code indicating the priority of this admission. Required for inpatient and LTC.</td></tr>
<tr><td colspan="4">Admission Codes</td></tr>
<tr><td>Code</td><td colspan="3">Description</td></tr>
<tr><td>1</td><td colspan="3">Emergency</td></tr>
<tr><td>2</td><td colspan="3">Urgent</td></tr>
<tr><td>3</td><td colspan="3">Elective</td></tr>
<tr><td>4</td><td colspan="3">Newborn</td></tr>
<tr><td>20</td><td colspan="4">ADMISSION SRC – Optional.</td></tr>
<tr><td>21</td><td colspan="4">D-HR – Indicate the Discharge Hour code for the timeframe the patient was discharged from inpatient care. Valid values are the same as form locator 18. Optional.</td></tr>
<tr><td>22*</td><td colspan="4">STAT – Provide the code indicating status as of the ending service date of the period covered. Required for inpatient and LTC.</td></tr>
<tr><td rowspan="5"></td><td colspan="4">Patient Status Codes</td></tr>
<tr><td>Code</td><td colspan="3">Description</td></tr>
<tr><td>01</td><td colspan="3">Discharged to home or self-care (routine discharge)</td></tr>
<tr><td>02</td><td colspan="3">Discharged or transferred to another short-term general hospital for inpatient care</td></tr>
<tr><td>03</td><td colspan="3">Discharged or transferred to skilled nursing facility (SNF)</td></tr>
<tr><td>04</td><td colspan="3">Discharged or transferred to an intermediate care facility (ICF)</td></tr>
</table>

(Continued)

Table 4 – UB-92 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	
	05	Discharged or transferred to another type of institution for inpatient care or referred for outpatient services to another institution
	06	Discharged or transferred to home under care of organized home health service organization
	07	Left against medical advice or discontinued care
	08	Discharged or transferred to home under care of a home intravenous provider
	20	Expired
	30	Still a patient or expected to return for outpatient services
	50	Discharged to hospice – home
	51	Discharged to hospice – medical facility
	61	Discharged or transferred within this institution to hospital based Medicare swing bed
	62	Discharged or transferred to another rehabilitation facility including discharge planning units of hospital
	63	Discharged or transferred to a long term care facility
	64	Discharged or transfer to a nursing facility Medicaid-certified but not Medicare-certified
	71	Discharge, transfer or referral to other institution for outpatient services as specified by discharge plan of care
	72	Discharge, transfer or referral to this institution for outpatient services as specified by discharge plan of care
23	MEDICAL RECORD NO. – Optional.	
24–30	**CONDITION CODES** – Provide the applicable code to identify conditions relating to this claim that may affect processing. A maximum of seven codes can be provided. **Required, if applicable.** The IHCP uses the following codes.	
	Condition Codes	
	Insurance Codes	
	Code	**Description**
	02	Condition is employment related
	03	Patient covered by insurance not reflected here
	05	Lien is filed
	07	Medicare hospice by non-hospice provider
	Accommodation Code	
	Code	**Description**
	40	Same day transfer

(Continued)

Table 4 – UB-92 Claim Form Locator Descriptions

<table>
<tr><th>Form Locator</th><th colspan="2">Narrative Description/Explanation</th></tr>
<tr><td rowspan="5"></td><td colspan="2">Prospective Payment Codes</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>61</td><td>Cost outlier</td></tr>
<tr><td>82</td><td>Non-covered by other insurance</td></tr>
<tr><td colspan="2">Special Program Indicator Codes</td></tr>
<tr><td></td><td>Code</td><td>Description</td></tr>
<tr><td></td><td>A7</td><td>Induced abortion, danger to life</td></tr>
<tr><td></td><td>A8</td><td>Induced abortion, victim of rape or incest</td></tr>
<tr><td>31</td><td colspan="2">UNLABELED FIELD – Use to indicate the PrimeStep (Hoosier Healthwise or Medicaid Select), Primary Care Case Management (PCCM), or primary medical provider (PMP) two-character alphanumeric certification code for the dates of service rendered. Required for members enrolled in the PrimeStep PCCM networks.</td></tr>
<tr><td rowspan="11">32a–35b</td><td colspan="2">OCCURRENCE CODE and DATE – Indicate the applicable code and associated date to identify significant events relating to this claim that may affect processing. Provide dates in a MMDDYY format. A maximum of eight codes and associated dates are allowed. Required, if applicable. The IHCP uses the following codes:</td></tr>
<tr><td colspan="2">Occurrence Codes</td></tr>
<tr><td>Code</td><td>Description and Usage</td></tr>
<tr><td>01</td><td>Auto accident</td></tr>
<tr><td>02</td><td>No fault insurance involved – including auto accident or other</td></tr>
<tr><td>03</td><td>Accident or tort liability</td></tr>
<tr><td>04</td><td>Accident or employment related</td></tr>
<tr><td>05</td><td>Other accident</td></tr>
<tr><td>06</td><td>Crime victim</td></tr>
<tr><td>25</td><td>Date benefits terminated by primary payer</td></tr>
<tr><td>27</td><td>Date home health plan established or last reviewed</td></tr>
<tr><td rowspan="3"></td><td>50</td><td>Previous hospital discharge – This code is used to bypass prior authorization (PA) editing when certain nursing and therapy services are to be conducted during the initial period following a hospital discharge. The discharge orders must include the requirement for such services. Details can be found in the applicable Indiana Administrative Code (IAC) section.</td></tr>
<tr><td>51</td><td>Date of discharge – This code is used to show the date of discharge from the hospital confinement being submitted, the date of discharge from a long-term care facility, or the date of discharge from home health care, as appropriate.</td></tr>
<tr><td>52</td><td>Initial examination – This code is used to show that an initial examination or initial evaluation, in a hospital setting, is being submitted. This code bypasses certain PA editing. Details can be found in the applicable IAC section.</td></tr>
</table>

(Continued)

Table 4 – UB-92 Claim Form Locator Descriptions

<table>
<tr><th>Form Locator</th><th colspan="2">Narrative Description/Explanation</th></tr>
<tr><td></td><td>53</td><td>Therapy evaluation, HHA – This code is used to show HHA for initial therapy evaluations. This code exempts the evaluation from PA editing. Revenue codes specific to therapy evaluations must be submitted. Details can be found in the applicable IAC section.</td></tr>
<tr><td></td><td>61</td><td>Home health overhead amount—one per day</td></tr>
<tr><td></td><td>62</td><td>Home health overhead amount—two per day</td></tr>
<tr><td></td><td>63</td><td>Home health overhead amount—three per day</td></tr>
<tr><td></td><td>64</td><td>Home health overhead amount—four per day</td></tr>
<tr><td></td><td>65</td><td>Home health overhead amount—five per day</td></tr>
<tr><td></td><td>66</td><td>Home health overhead amount—six per day</td></tr>
<tr><td>36a–b</td><td colspan="2">OCCURRENCE SPAN CODE, FROM/THROUGH – Provide the code and associated dates for significant events relating to this claim. Each Occurrence Span Code must be accompanied by the span From and Through date. The only valid home health overhead Occurrence Span Code is 61. Optional.</td></tr>
<tr><td></td><td colspan="2">Occurrence Span Code</td></tr>
<tr><td></td><td>Code</td><td>Description</td></tr>
<tr><td></td><td>61</td><td>Home health overhead amount—one per day</td></tr>
<tr><td>37a</td><td colspan="2">UNLABELED FIELD – If the inpatient claim submitted is more than one page, indicate continuation claim in this field. All continuation claim pages must indicate continuation claim and page 1 of 2 or page 2 of 2 in this data element. Continuation claims are limited to a maximum of 45 service lines (two pages). Optional.</td></tr>
<tr><td>37b–c</td><td colspan="2">UNLABELED FIELD – Not applicable.</td></tr>
<tr><td>38</td><td colspan="2">UNLABELED FIELD – Not applicable.</td></tr>
<tr><td>39a–41d*</td><td colspan="2">VALUE CODES –Use these fields to identify MRN information. The following value codes must be used along with the appropriate dollar amounts for each:
• Value Code A1 – Medicare deductible amount
• Value Code A2 – Medicare co-insurance amount
• Value Code 06 – Medicare blood deductible amount</td></tr>
<tr><td>42</td><td colspan="2">REV. CD. – Provide the applicable revenue code identifying the specific accommodation, ancillary service, or billing calculation. The appropriate revenue code must be provided to explain each charge indicated in form locator 47. Refer to the IAC for covered services, limitations, and medical policy rules. Use the specific revenue code when available. Required.</td></tr>
<tr><td>43*</td><td colspan="2">DESCRIPTION – Enter a narrative description of the related revenue code category on this bill. Abbreviations may be used. Only one description per line. Optional.</td></tr>
<tr><td>44*</td><td colspan="2">HCPCS/RATES – Use the HCPCS code applicable to the service provided. Only one service code per line is permitted. Required for home health, outpatient, and ASC services. This field is also used identify procedure code modifiers. Provide the appropriate modifier, as applicable. Up to four modifiers are allowed for each procedure code. This is an eight-character field. Required, if applicable.</td></tr>
<tr><td>45*</td><td colspan="2">SERV. DATE – Provide the date the indicated outpatient service was rendered. Required for home health, hospice, independent laboratories, dialysis, ASC, and outpatient.</td></tr>
</table>

(Continued)

Table 4 – UB-92 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
46*	**SERV. UNITS** – Provide the number of units corresponding to the revenue code or procedure code submitted. Six digits are allowed and 9999.99 units is the maximum that can be submitted. The procedure code and revenue code must be billed using whole numbers. **Required.**
47	**TOTAL CHARGES** – Provide the total charges pertaining to the related revenue code for the statement covers period. Provide the revenue code 001 to indicate totals, with the sum of all charges billed reflected in form locator 47. Nine digits are allowed per line, such as 9999999.99. **Required.**
48	NON-COVERED CHARGES – Not applicable. Information in this block and applied to the claim results in an out-of-balance bill and subsequent denial. **Do not enter information in this form locator field.**
49	UNLABELED FIELD – Not applicable.
50a–55c	For form locators 50a-55c – Medicare is always listed first (50a), if applicable. Other insurers, such as a Medicare supplement (commercial insurer), are listed in the second form locator (50b), if applicable. The IHCP information is listed last (50c). EXCEPTION: Section 5-1 notes that the IHCP is primary to Children's Special Health Care Services (CSHCS) and Victim Assistance coverage**. Required, if applicable.** For form locators 58a through 62c – Provide the data relative to the entries in form locators 50a through c, such as Medicare, Medicare supplement, and Traditional Medicaid/spend-down. **Required, if applicable.**
50a	**PAYER** – Provide the Medicare carrier's name. **Required, if applicable**.
50b	**PAYER** – Provide the Medicare supplement carrier's name or private insurance carrier's name. **Required, if applicable**.
50c	**PAYER** – Provide the applicable IHCP, such as Traditional Medicaid, 590 Program, or Hoosier Healthwise. If the member is a spend-down category, indicate spend-down on the same line (50C) as the applicable IHCP, such as Traditional Medicaid/spend-down. **Required**.
51a–51c	**PROVIDER NO.** – Indicate the provider number for the corresponding payer listed in form locator 50a–c. **The billing IHCP provider number is required**, others are optional. An example of a complete IHCP provider number is 123456789X, nine numeric characters and an alpha character for the service location code.
52a–52c	REL INFO – Not applicable.
53a–53c	ASG BEN – Mark **Y** for Yes, benefits assigned. The IHCP provider agreement includes details about accepting payment for services. Optional.
54a–54c*	**PRIOR PAYMENTS** – Enter the amount paid by the carrier entered in form locators 50a-b, as applicable. The spend-down deductible from the *DPW Form 8A* is entered in form locator 54c for Traditional Medicaid. **Required, if applicable**. Note: When a TPL carrier makes payment on a claim, the Explanation of Benefits (EOB) is not required. If the Medicare payment is greater than zero, the MRN is not required.
55a–55b	EST. AMOUNT DUE – Not applicable.

(Continued)

Table 4 – UB-92 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	
55c	**EST. AMOUNT DUE** – Indicate the amount submitted for the service. Form locator 47 Revenue Code 001 TOTAL CHARGES minus form locators 54a through 54c PRIOR PAYMENTS equals the EST. AMOUNT DUE. This form locator accommodates nine digits, such as 9999999.99. **Required**.	
56	Unlabeled Field – Not applicable.	
57	DUE FROM PATIENT – Indicate the amount due from the member for personal convenience and other non-covered items requested by the member, see *Charging the Member for Non-covered Services*. **Required, if applicable**.	
58a–58c	**INSURED'S NAME** – Provide the member's LAST NAME, FIRST NAME, and MIDDLE INITIAL. The IHCP member information is required in form locator 58c. Indicate Medicare and third party liability information as appropriate. **Required, if applicable**.	
59a–59c	P. REL – Not required.	
60a–60c	**CERT.–SSN–HIC. –ID NO**. – Provide the member's identification number for the respective payers indicated in form locators 50a–c. The 12-digit IHCP member ID (RID) number is **required** in form locator 60c. Refer to form locator 50c for the IHCP member program. Other carrier identification information is **required** in 60a and b, **if applicable**.	
61a–61c	**GROUP NAME** – Indicate the name of the group or plan providing other insurance to the member by the respective payers identified in form locators 50a–c. **Required, if applicable**.	
62a–62c	**INSURANCE GROUP NO.** – Provide the identification number, control number, or code assigned by the carrier or administrator to identify the group covering the individual, refer to form locators 50a–b. Indicate the policy number as well. **Required, if applicable**.	
63a–63c	TREATMENT AUTHORIZATION CODES – Provide the number that indicates the payer authorized the treatment provided. Optional.	
64a–64c	**ESC** – Indicate the employment status code of the insured. **Required, if applicable**.	
	Employment Status Codes	
	Code	**Description**
	1	Employed full time
	2	Employed part time
	3	Not employed
	4	Self-employed
	5	Retired
	6	On active military duty
	9	Unknown
65a–65c	**EMPLOYER NAME** – Provide the name of the employer that may provide or does provide health care coverage for the insured individual identified in form locator 58. **Required, if applicable**.	
66a–66c	**EMPLOYER LOCATION** – Provide the specific location of the employer identified in form locators 65a through c. **Required, if applicable.**	

(Continued)

Table 4 – UB-92 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
67*	**PRIN. DIAG. CD**. – Provide the International Classification of Diseases, 9th Edition Clinical Modification (ICD-9-CM) code describing the principal diagnosis, for example, the condition established after study to be chiefly responsible for the admission of the patient for care. **Required for inpatient, outpatient, LTC, hospice, ASC, and home health.**
68–75*	**OTHER DIAG. CODES** – Provide the ICD-9-CM codes corresponding to additional conditions that coexist at the time of admission, or that develop subsequently, and that have an effect on the treatment received or the length of stay. **Required, if applicable, for inpatient, outpatient, hospice, ASC, and home health.**
76	**ADM. DIAG. CD** – Use the ICD-9-CM code provided at the time of admission as stated by the physician. **Required for inpatient and LTC**.
77*	**E-CODE** – If used, use the appropriate E-code provided at the time of admission as stated by the physician. **Required, if applicable.**
78	UNLABELED FIELD – Not applicable.
79	P.C. – Not applicable.
80*	**PRINCIPAL PROCEDURE CODE/DATE** – Use the ICD-9-CM procedure code that identifies the principal procedure performed during the period covered by this claim, and the date the principal procedure described on the claim was performed. **Required for inpatient procedures**.
81*	**OTHER PROCEDURE CODE/DATE** – Use the ICD-9-CM procedure codes identifying all significant procedures other than the principal procedure, and the dates, identified by code, the procedures were performed. Report the codes that are most important for the encounter and specifically any therapeutic procedures closely related to the principal diagnosis. **Required, when appropriate, for inpatient procedures**.
82	ATTENDING PHYS. ID – Use the eight-digit Indiana license number of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered or who is primarily responsible for the patient's medical care and treatment. Optional.
83A*	**OTHER PHYS. ID** – Use the license number of the physician performing the principal procedure. **Required for inpatient procedures**.
83B	**OTHER PHYS. ID** – Use the eight-digit license number of the Hoosier Healthwise PMP. **Required for Hoosier Healthwise members enrolled in the Prime*Step* PCCM network.**
84*	REMARKS – Use this field for *Claim Note Text*. Provide information, up to 80 characters, that may be helpful in further describing the services rendered. *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.*
85	**PROVIDER REPRESENTATIVE** – This must be an authorized signature indicating that the information submitted on the face of this claim is in conformance with the certifications on the back of the claim. A stamped signature is acceptable; however, a typed signature is not. **Required, unless the *Signature on File* form has been completed and is included in the provider enrollment file.**
86	**DATE** – Indicate the date the claim is submitted in MMDDYY format. **Required.**

Dental Claim Form Requirements

Effective for dates of submission of November 14, 2003, and after, the *ADA 1999 Version 2000 Dental Claim Form* (referred to as the ADA 2000 dental claim form) is required for dental service claims submitted by dental providers. EDS does not supply dental claim forms and they will not be available on the IHCP Web site. Dental claim forms can be obtained from several sources including the American Dental Association at 1-800-947-4746. Claims submitted on any other claim form will be returned to the provider.

> *Note: The Current Dental Terminology Fourth Edition (CDT-4) code changes discussed in the dental section of this bulletin will be implemented January 1, 2004.*

Procedure Code Multiple Units

The IHCP will accept multiple units per service line for applicable dental procedure codes on the ADA 2000 claim form. The dental provider will be able to submit multiple units on one claim service line. For example, *D1110 Prophylaxis - adult* would not be appropriate for submitting multiple service units; however, *D4341 Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces, per quadrant* could be submitted with up to four units on one service line with the number of quadrants treated on the date of service.

The multiple units must be rendered on the same date of service and a single service line cannot span more than one date. All procedure code limitations remain in place and services that exceed these limitations are reduced to the unit limitation for the procedure code. This change is effective November 14, 2003, and after, for all paper dental claims.

CDT-4 Procedure Codes

Effective for dates of service on or after January 1, 2004, all IHCP dental codes not listed as CDT-4 procedure codes will be end dated in Indiana*AIM*. Table 5 lists the new billing code information for all CDT-3 procedure codes that are currently in Indiana*AIM* that will be end dated December 31, 2003.

> *Note: CDT-4 code changes discussed in this section will be implemented January 1, 2004. All other dental changes for paper claims are effective November 14, 2003.*

Tooth Numbers and Tooth Surfaces for CDT-4 Codes

Certain CDT-4 codes require a tooth number on the service line associated with the CDT-4 procedure code. The IHCP only accepts one tooth number per service line. All requirements for tooth number identification are included in Table 5. Additionally, some CDT-4 codes must be billed using the appropriate tooth surface codes. The crosswalked CDT-4 codes that require a tooth surface for billing, as well as the minimum number of tooth surface codes required for each procedure code, are also noted in Table 5. See Chapter 8 of the *IHCP Provider Manual* for a full listing of CDT codes that require a valid tooth number and a valid tooth surface for claim submission. IHCP provider bulletin *BT200321* includes a listing of current IHCP covered dental codes.

> *Note: All IHCP dental codes must follow the CDT-4 procedure code description effective January 1, 2004. This requirement revises the current IHCP provider manual and previous bulletin documentation.*

Table 5 – CDT-3 to CDT-4 Crosswalk

CDT-3 Procedure Code	CDT-4 Procedure Code	Valid Tooth Numbers	Valid Number of Tooth Surfaces
D2110 Amalgam – one surface, primary	**D2140** Amalgam – one surface, primary or permanent	A – T 1 – 32	One
D2120 Amalgam – two surfaces, primary	**D2150** Amalgam – two surfaces, primary or permanent	A – T 1 – 32	Two
D2130 Amalgam – three surfaces, primary	**D2160** Amalgam – three surfaces, primary or permanent	A – T 1 – 32	Three
D2131 Amalgam – four or more surfaces, primary	**D2161** Amalgam – four or more surfaces, primary or permanent	A – T 1 – 32	Minimum of four
D2380 Resin-based composite – one surface, posterior primary	**D2391** Resin-based composite – one surface, posterior	A, B, I, J, K, L, S, T 1-5, 12-21, 28-32	One
D2381 Resin-based composite – two surfaces, posterior primary	**D2392** Resin-based composite – two surfaces, posterior	A, B, I, J, K, L, S, T 1-5, 12-21, 28-32	Two
D2382 Resin-based composite – three or more surfaces, posterior primary	**D2393** Resin-based composite – three surfaces, posterior **D2394** Resin-based composite – four or more surfaces, posterior	A, B, I, J, K, L, S, T 1-5, 12-21, 28-32 A, B, I, J, K, L, S, T 1-5, 12-21, 28-32	Three Minimum of four
D7110 Extraction – single tooth	**D7140** Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A – T 1 – 32	N/A
D7120 Extraction – each additional tooth	**D7140** Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A – T 1 – 32	N/A
D7130 Root removal – exposed roots	**D7140** Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A – T 1 – 32	N/A

Dental Extractions

Effective for dates of service on or after January 1, 2004, the following billing requirements and reimbursement policies apply to tooth extractions. Only one tooth number is allowed per service line.

A provider submitting a claim for *D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)* must indicate the tooth number for each tooth extracted on a separate service line in field 59 on the ADA 2000 dental claim form. The IHCP will pay 100 percent of the maximum allowed amount or the billed amount, whichever is less, for the initial extraction. For multiple extractions within the same quadrant on the same date of service, the IHCP will pay 90 percent of the maximum allowed amount for procedure code D7140 or the billed amount, whichever is less.

Dental Claim Form Changes

The IHCP previously accepted any dental claim form. Effective November 14, 2003, the IHCP accepts only the ADA 2000 dental claim form. Because the form layouts are different, this section provides an overview of the HIPAA-required information and new requirements for the ADA 2000 dental claim form. Each field indicates if the field is required, required if applicable, optional, or not applicable, effective November 14, 2003.

> *Note: The entire ADA 2000 dental claim form is new. However, the following changes noted below are for affected form locator fields due to HIPAA-related changes.*

Changes Corresponding to the HIPAA-Required 837 Dental Transaction and the ADA 2000 Dental Claim Form Requirements

- Field 53 *Radiographs or Models Enclosed?* – Use this field to indicate services provided were for emergency care. Mark the appropriate box. (Required)
- Field 59 *Examination and Treatment Plan*
  - *Qty* – The procedure can be submitted using partial or multiple units, if appropriate. This field accommodates six digits, such as 9999.99. (Required)
  - *Payment by Other Plan* – Use this field to provide any payment received from another insurance source. (Required, if applicable)
  - *Carrier %* – This field is no longer applicable.

Clarification of the ADA 2000 Claim Form

- Field 59 *Examination and Treatment Plan*
  - *Date* – This field has changed from MMDDYY format to MMDDYYYY format. (Required)

All form locator fields with a change are noted with an asterisk (*) in Table 6.

ADA 2000 Dental Claim Form Fields

Instructions for completing the dental claim form are in this section. Each field of the ADA 2000 dental claim form is described in Table 6. The form locator chart indicates in bold fields that are required or required, if applicable. The instructions describe each form locator, or data element, by referring to the number found in the left corner of each box on the dental claim form.

Several fields are not numbered. These fields are listed as *unlabeled*. The narrative sequence moves from left to right, top to bottom, across the claim form.

Note: The IHCP will only accept the ADA 1999 version 2000 dental claim form effective November 14, 2003. Claims submitted on any other version will be returned to the provider. Each claim form must have all required fields completed, including a total dollar amount. Only one procedure code can be listed per service line. If the number of service lines exceeds the number of service lines allowed on the form, an additional claim form must be completed.

Table 6 – Dental Claim Form Field Locator Descriptions

Form Locator	Narrative Description/Explanation
1	**Dentist's pretreatment estimate/Dentist's statement of actual services:** Mark the box stating, *Dentist's statement of actual services*. **Required.**
2	**CHECK ONE –** Mark **Medicaid Claim**. **Required.** **EPSDT:** Mark, if applicable. Prior Authorization #: Not applicable.
3	CARRIER NAME: Optional.
4	CARRIER ADDRESS**:** Optional.
5	CITY: Optional.
6	STATE: Optional.
7	ZIP: Optional.
Fields 8 through 18 provide member information. Fields 19 through 30 provide policyholder information for individuals other than the member; for example, a parent's policy with dependent coverage, or another individual who is court ordered to provide insurance for the member. Fields 31 through 37 also provide additional member insurance information for members with more policies than Fields 19 through 30 can accommodate.	
8	**PATIENT NAME: LAST, FIRST, M.I.** – Provide the member's last name, first name, and middle initial as found on the member's RID card. **Required.**
9	ADDRESS: Optional.
10	CITY: Optional.
11	STATE: Optional.
12	DATE OF BIRTH: Optional.
13	**PATIENT ID #:** Provide the IHCP member's RID number. This field accommodates the 12 numeric characters. **Required.**
14	**SEX**: M, F – Mark the appropriate box. **Required.**
15	PHONE NUMBER: Optional.
16	ZIP CODE: Optional.
17	**RELATIONSHIP TO SUBSCRIBER/EMPLOYEE:** Mark **Self**. The IHCP member is always the subscriber. **Required.**
18	EMPLOYER/SCHOOL: Optional.

(Continued)

Table 6 – Dental Claim Form Field Locator Descriptions

Form Locator	Narrative Description/Explanation
19	**SUBSCRIBER/EMPLOYEE I.D. NUMBER/SOC. SEC. NUMBER** – Provide the policyholder's Social Security or ID number for the policy identified in fields 31 and 32. **Required, if applicable.**
20	**EMPLOYER NAME AND ADDRESS** – Provide the requested member information. **Required, if applicable.**
21	**GROUP NUMBER** – Provide the member's employer-related insurance information. **Required, if applicable.**
22	**SUBSCRIBER/ EMPLOYEE NAME:** Provide the member's last name, first name, and middle initial as found on the member's benefit card. **Required, if applicable.**
23	**ADDRESS** – Provide the requested member information. **Required, if applicable.**
24	PHONE NUMBER: Optional.
25	**CITY: Required, if applicable.**
26	**STATE: Required, if applicable.**
27	**ZIP CODE: Required, if applicable.**
28	DATE OF BIRTH: MM, DD, YY – Provide the member's birth date in MMDDYY format. Optional.
29	MARITAL STATUS: Optional.
30	SEX: M, F – Mark the appropriate box. Optional.
31	**IS PATIENT COVERED BY ANOTHER PLAN?** – Mark the appropriate box. If yes, indicate type and complete fields 32 through 37. **Required, if applicable.**
32	**POLICY NUMBER: Required, if applicable.**
33	**OTHER SUBSCRIBER NAME:** If another insurance is available and the policyholder is other than the member indicated in fields 31 through 32, provide the policyholder's name. **Required, if applicable.**
34	**DATE OF BIRTH: MM, DD, YY** – If another insurance is available and the policyholder is other than the member indicated in fields 4 through 10, provide the policyholder's birth date in MMDDYY format. **Required, if applicable.**
35	SEX: M, F – Mark the appropriate box. Optional.
36	PLAN/PROGRAM NAME: Provide the requested information. **Required, if applicable.**
37	EMPLOYER/SCHOOL: Provide the requested information. **Required, if applicable.**
38	SUBSCRIBER/EMPLOYEE STATUS: Provide the requested information. Optional.
39	SIGNED (PATIENT/ OR GUARDIAN) – Not applicable. DATE – Not applicable.
40	EMPLOYER/SCHOOL: Provide the requested information. Optional.
41	SIGNED (EMPLOYEE/SUBSCRIBER) – Not applicable. DATE – Not applicable.
Fields 42 through 57 indicate provider and treatment/plan of care information.	
42	**NAME OF BILLING DENTIST OR DENTAL ENTITY** – Indicate the provider's name. **Required.**
43	PHONE NUMBER: – Indicate the provider's complete phone number. The information is important should EDS need to contact the provider about the claim. Optional.

(Continued)

Table 6 – Dental Claim Form Field Locator Descriptions

Form Locator	Narrative Description/Explanation	
44	**PROVIDER ID #:** Indicate the IHCP billing provider number. Accommodates nine digits plus one alpha character**. Required.**	
45	**DENTIST SOC. SEC. OR T.I.N.** – Provide the Social Security or tax ID number for the billing provider (group or sole proprietor). Accommodates nine numeric characters. **Required.**	
46	**ADDRESS** – Indicate the provider's street address or P.O. box number. **Required.**	
47	**DENTIST LICENSE NO**. – Optional.	
48	FIRST VISIT DATE OF CURRENT SERIES – Optional.	
49	**PLACE OF TREATMENT: OFFICE, HOSP, ECF, OTHER** – Indicate the type of facility where treatment was rendered. Mark the appropriate box to indicate regular service. **Required.**	
50	**CITY – Required.**	
51	**STATE – Required.**	
52	**ZIP CODE– Required.**	
53*	**RADIOGRAPHS OR MODELS ENCLOSED?** – Use this field as **EMERGENCY INDICATOR** to specify services provided were for emergency care. Mark the appropriate box. **Required.**	
54	IS TREATMENT FOR ORTHODONTICS? – Optional. If **Yes** is marked, provide the additional information requested. IF SERVICES ALREADY COMMENCED: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING. Optional.	
55	**IF PROSTHESIS, IS THIS INITIAL PLACEMENT?** – No/Yes, if no, provide the reason for replacement. Indicate the requested information, as appropriate. **Required, if applicable.**	
56	**IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?** – Mark the appropriate box. If **Yes**, is marked, provide a brief description and dates. **Required.**	
57	**IS TREATMENT RESULT OF AUTO ACCIDENT, OTHER ACCIDENT, NEITHER?** – Mark the appropriate box. Provide a brief description and dates. **Required, if applicable.**	
Fields 58 through 61 provide diagnosis and treatment information.		
58	Diagnosis Code Index – Provide the ICD-9-CM diagnosis codes in priority order. Eight codes are allowed. Optional.	
59	**Examination and Treatment Plan**	
	Field Name	**Field Description/Explanation**
*	**DATE (MM/DD/YYYY)**	Provide the date the service was rendered in MMDDYYYY format; for example 12202002. **Required.**
	TOOTH # OR LETTER	Provide the tooth number or letter for the service rendered. **Required** for any procedure performed on an individual tooth.

(Continued)

Table 6 – Dental Claim Form Field Locator Descriptions

Form Locator	Narrative Description/Explanation	
	SURFACE	Provide the tooth surface for the service rendered. **Required, if applicable.**
	DIAGNOSIS INDEX #	Not applicable.
	PROCEDURE CODE	Provide the appropriate ADA CDT procedure code. **Required.**
*	**Qty**	Provide the appropriate number of units for the service rendered. The IHCP accepts multiple units and partial units for applicable procedure codes. Up to six digits are allowed, including two decimal places. **Required.**
	DESCRIPTION	Not applicable.
	FEE	Provide the amount charged for the procedure code. Up to eight digits are allowed, including two decimal places. **Required.**
	TOTAL FEE	Provide the total of all the individual service line charges. Up to eight digits are allowed, including two decimal places. **Required.**
*	**PAYMENT BY OTHER PLAN**	Provide any payment received from another insurance source. All applicable items are combined and the total indicated in this field. Up to eight digits are allowed, including two decimal places. **Required, if applicable.** Provide the amount paid by other insurers. If other insurers were billed, but paid zero, place **0** in the *Payment By Other Plan* field. Submit the claim form with the denials attached.
		If other insurance fails to respond after 90 days, or 30 days for paternity, the provider should submit the claim to EDS and attach documentation supporting the provider's efforts to collect from the primary carrier. The provider should indicate in bold type, **90-DAY RULE** in field 22. This procedure prompts EDS to suppress the third party liability (TPL) edit during claims processing. EDS continues to pursue payment from the primary carrier. **For spend-down members, the *DPW Form 8A* must be attached to the claim form.**
	MAX. ALLOWABLE	Not applicable.
	DEDUCTIBLE	Not applicable.
*	CARRIER %	Not applicable.
	CARRIER PAYS	Not applicable.
	PATIENT PAYS	Provide the net charge: Total fee charged minus the payment by other plan (what has been paid by TPL). Up to eight digits are allowed. **Required.**
60	IDENTIFY MISSING TEETH WITH X – Mark the diagram as directed. Optional.	

(Continued)

Table 6 – Dental Claim Form Field Locator Descriptions

Form Locator	Narrative Description/Explanation
61	**REMARKS FOR UNUSUAL SERVICES** – Provide any information, up to 80 characters, that may be helpful in further describing the services rendered. For anesthesia or analgesia service, indicate the number of units or length of time the services were rendered. **Required, if applicable.**
Unlabeled	ADMINISTRATIVE USE ONLY – Not applicable.
62	**SIGNED (TREATING DENTIST)** – An authorized person, someone designated by the provider, or the dentist must sign and date the claim. A signature stamp is acceptable; however, a typed signature is not acceptable. **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 submitted in a MMDDYYYY format. **Required.**
63	ADDRESS WHERE TREATMENT WAS PERFORMED – Provide the street address where the services were rendered. Optional.
64	CITY– Optional
65	STATE – Optional.
66	ZIP CODE– Optional.

Paper Attachment Requirements

Effective for claim submission dates of September 26, 2003, and after, the IHCP will accept paper attachments with electronic claims (837I, 837P, and 837D). Web interChange claims will follow the same attachment requirements effective October 2, 2003, and after.

Paper Attachments with Electronic Claims

When an 837 claim transaction requires the submission of additional documentation, the documentation can be submitted as a paper attachment. When a provider elects to send a paper attachment with an 837 transaction, the following information must be included on the 837 transaction:

- *Attachment Transmission Code* – Required to indicate if an electronic claim has paper documentation to support the billed services. This code defines the timing and transmission method or format of reports and how they are sent. This value is provided in Attachment Transmission Code, Data Element 756, on the 837 transaction. All valid Attachment Transmission Codes are accepted for the 837 transactions; however, the IHCP only accepts paper attachments for electronic or paper claims by mail. This Attachment Transmission Code is *BM* (by mail).
- *Attachment Report Type Code* – Indicates the type of attachment being sent to the IHCP to support the 837 claim data. The code indicates the title or contents of a document, report, or supporting item. This code is entered in Report Type Code, Data Element 755. For a complete listing of Attachment Report Type Codes, refer to the 837 claim transaction implementation guide. Examples include the following:
  - B3 – Physician order
  - B4 – Referral form
  - EB – Explanation of benefits
  - OZ – Support Data for Claim
    - Use for:

- Progress notes
- Invoices (manual pricing)
- DME delivery tickets
- Transportation run tickets
- Sterilization/hysterectomy consent forms
- Spend-down Form 8A
- Past filing limit documentation
- PA request/response copies
- Environmental modification service requests
- Consultation reports

- Attachment control number (ACN) – This code identifies each attachment. The ACN is created by the provider and can be numbers, letters, or a combination of letters and numbers. ACN numbers can be up to 30 characters in length. This code is entered in Attachment Control Number, Data Element 67.

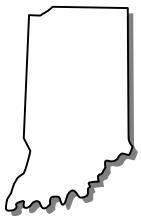
The following instructions must be followed when submitting paper attachments for electronic claims:

- Each paper attachment submitted for an 837 transaction must include an ACN. There should be a unique ACN number written on each attachment. If an attachment has more than one page, the ACN number must be written on each page of the document.
- The provider must send an IHCP *Claims Attachment Cover Sheet* for each set of attachments associated with a specific claim. A copy of the IHCP *Claim Attachment Cover Sheet* can be found on the IHCP Web site at www.indianamedicaid.com or in Figure 1. The provider must complete the following information on the *IHCP Claims Attachment Cover Sheet*:
  - Billing provider number
  - Dates of service for which the attachment is associated
  - The member identification number (IHCP RID number)
  - ACN
  - Number of pages associated with each attachment
- A maximum of 20 ACN numbers can be submitted with each attachment cover sheet. A separate cover sheet should be used for any single claim with more than 10 attachments. Otherwise, ACN information for multiple claims can be entered on one cover sheet.
- The ACN must be unique per document and documents cannot be shared between claims.
- Paper attachments for electronic claims must be mailed to the IHCP at the following address:

  EDS Claims Attachments
  P.O. Box 7259
  Indianapolis, IN 46207

The EDS Claims Support Unit will review each *Claims Attachment Cover Sheet* for completeness and accuracy of the number of ACNs to the number of attachments. If errors are found, the cover sheet and attachments are returned to the provider for correction and resubmission. If the attachments are not received within 45 days of claim submission, the claims auto deny. If attachments have been received, but one specific attachment needed for processing is missing from the batch, the claim or service line denies.

Indiana Health Coverage Programs



CLAIMS ATTACHMENT COVER SHEET

Provider name _____

Provider address _____

City, State, ZIP _____

In order to process your attachment(s), this form must be completed as follows:

- Complete a separate form for each claim.
- Write the appropriate attachment control number (ACN) on each attachment.
- Place this form on top of the attachment(s) for each claim.

Attachment Information	
Billing provider number, nine numeric and one alpha character	
Dates of service (From and To dates from the claim)	
RID number	

ACN	Number of Pages	ACN	Number of Pages

Figure 1 – Claims Attachment Cover Sheet

Paper Attachments with Paper Claims

The process for submitting paper claims with attachments is not changing. Providers should continue to follow current procedures for submitting paper claims with attachments.

HIPAA Implementation Updates

Local Code Updates

Please note the following corrections to bulletin *BT200353*:

- Page 14, Table 12, A0380 was cross walked to A0425 rather than A02425.
- Page 14, Table 12, A0390 was cross walked to A0425 rather than A02425.
- Page 52, Table 16, Y0501 was cross walked to 99539 rather than 99600.

Table 7 lists modifications to the local code crosswalk information published in *BT200353*. These crosswalk solutions no longer require the use of a provider taxonomy code as previously published. Additionally, the time units for the new crosswalked procedure codes may be different from the current local procedure code descriptions. However, the reimbursement rates are not changing due to this implementation.

Table 7 – Updated Local Code Crosswalk Information

Local Code	Description	Crosswalked Procedure Code/Modifier Combination	Description
X3015	Occupational therapy (HHA) (1/4 hour=1 unit)	G0152, U7, UA	G0152 – Services of occupational therapist in home health setting, each 15 minutes U7 – Waiver UA – Provider
X3017	Physical therapy (HHA) (1/4 hour=1 unit)	G0151, U7, UA	G0151 – Services of physical therapist in home health setting, each 15 minutes U7 – Waiver UA – Provider
Z5605	Respite/homemaker (HHA/HSA), 1 hour=1 unit	S5150, U7, UA, UB	S5150 – Unskilled respite care, not hospice; each 15 minutes U7 – Waiver UA – Provider UB – Homemaker

(Continued)

Table 7 – Updated Local Code Crosswalk Information

Local Code	Description	Crosswalked Procedure Code/Modifier Combination	Description
Z5606	Respite/attendant care/personal assistance/resid. care/comm. resid. services, 1 hour=1 unit	S5150, U7, UA, UC	S5150 – Unskilled respite care, not hospice; each 15 minutes U7 – Waiver UA – Provider UC – Personal care attendant
Z5654	Respite/homemaker, non-agency, 1 hour=1 unit)	S5150, U7, UB	S5150 – Unskilled respite care, not hospice; each 15 minutes U7 – Waiver UB – Homemaker
Z5655	Respite/attendant care/personal assistance, non-agency, 1 hour=1 unit	S5150, U7, UC	S5150 – Unskilled respite care, not hospice; each 15 minutes U7 – Waiver UC – Personal care attendant

Provider Electronic Solutions Updates

Providers are reminded that Provider Electronic Solutions will not be supported after October 16, 2003. The last effective date for claims submission via Provider Electronic Solutions is October 15, 2003. Alternative methods of electronic claims submission include using Web interChange or contracting with an approved vendor to submit HIPAA-compliant claims. A list of approved vendors is available on the IHCP Web site.

Direct questions about this information to the Electronic Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.

> *Note: All IHCP providers are encouraged to contact their current software vendors or clearinghouses to determine if they have started testing with the IHCP for HIPAA electronic transactions. Additionally, verify that your billing system supports the paper claim requirements discussed in this bulletin.*

Additional Information

Direct questions about this bulletin to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.