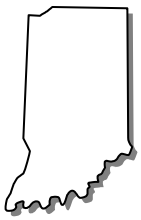

P R O V I D E R B U L L E T I N

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

To: Diagnostic and Evaluation Teams and Community Mental Health Centers

Subject: Pre-Admission Screening and Resident Review Level II Claims Processing Change

Overview

The purpose of this bulletin is to provide information about the automation of Pre-Admission Screening and Resident Review (PASRR) Level II claims processing.

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

Effective July 1, 2005, providers should submit PASRR claims to EDS using the paper CMS-1500 claim form, the electronic 837 Professional Claims and Encounters (837P) Transaction format, or Web interChange.

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

The provider should submit these claims for the member using the PASRR member identification number that begins with **800** and the member's social security number. If an applicant does not have or refuses to provide a social security number Providers may contact the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 to obtain a PASRR identification number.

The nursing facility PASRR was federally mandated under the 1987 nursing facility reform. All individuals applying for admission to Medicaid-certified nursing facilities, regardless of their source of payment, must be pre-screened through the PASRR Level I process to identify those individuals who may be mentally ill (MI) or Mentally Retarded/Developmentally Disabled (MR/DD). A PASRR Level II assessment will then be conducted by the Community Mental Health Centers (CMHCs) for nursing facility residents who may be MI, and by the Diagnostic and Evaluation (D&E) Team for nursing facility residents who may be MR/DD. Nursing facility residents may also be required to be assessed

under the Resident Review (RR) Level II process if they are identified as possibly being MI or MR/DD and were not assessed through the PASRR program prior to admission, or have had a substantial change in condition related to their MI or MR/DD condition, which may require a change in services or placement.

All PASRR claims are edited against the State PASRR database prior to reimbursement. CMHCs and D&E Teams may submit claims for PASRR Level II assessments conducted as a result of a Level I referral. Providers should terminate a PASRR Level II assessment immediately if it is determined that the Level I referral was not appropriate (for example, applicant not DD, has a primary diagnosis of dementia, and so forth) and the submitted claim should reflect a reduced fee as appropriate for the individual assessment.

Providers can obtain information about how to submit claims using the CMS-1500 paper claim, the electronic 837P transaction, or Web interChange by visiting the IHCP Web site at http://www.indianamedicaid.com. This Web site includes Web interChange instructions, Companion Guides for Electronic Data Interchange (EDI) Solutions Transactions, the current *Indiana Health Coverage Programs (IHCP) Provider Manual*, a provider field representative telephone listing, and additional IHCP information. For answers to specific questions, providers may also call EDS Customer Assistance at (317) 655-3240 in the Indianapolis local are or 1-800-577-1278.

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

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

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

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

Diagnostic and Evaluation Teams

D&E Teams must be contracted and approved by the Division of Disability, Rehabilitative Services (DDRS, formerly the Division of Disability, Aging and Rehabilitative Services (DDARS)), Bureau of Developmental Disability Services (BDDS) to conduct the PASRR Level II MR/DD assessments and be enrolled with the IHCP to be eligible to submit Level II MR/DD claims. Providers may obtain a list of contracted and authorized D&E Teams from DDRS.

Community Mental Health Centers

CMHCs must be contracted and approved by the Division of Mental Health and Addiction (DMHA) to conduct the PASRR Level II MR/DD assessments and be enrolled with the IHCP to be eligible to submit Level II MR/DD claims. Providers may obtain a list of contracted and authorized CMHCs from the DMHA.

Billing Procedures

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

- *Provider Enrollment*: New D&E Teams and CMHCs are only approved to conduct PASRR Level II assessments through contractual arrangements with DDRS and DMHA. The OMPP will refer the names of new entities to the EDS Provider Enrollment Unit for further enrollment processing. PASRR providers who are currently enrolled as IHCP providers do not need to re-enroll. The current IHCP provider ID number that has been assigned for Medicaid or other non-waiver IHCP programs will be the provider's PASRR provider ID number. If a current provider ID does not exist, the provider must enroll as a PASRR provider.

  To enroll as a PASRR provider and to obtain a valid provider ID to submit PASRR claims, providers should visit the IHCP Web site at http://www.indianamedicaid.com, to obtain and complete enrollment applications.

  Providers should submit completed applications to the following address:

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

- PASRR applicant(s) or member(s) may be dually eligible in the IHCP.
  - When providers submit claims for PASRR, the provider must use the PASRR member ID that consists of **800** and the applicant's Social Security Number, or the applicant's PASRR identification number (for example, 800999999999).
  - At no time shall a member bear financial responsibility for a PASRR Level II assessment.

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

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

- Providers submitting claims using the Web interChange must meet the technical requirements for Web interChange access, and have a valid Web interChange account and password. Providers should allow five business days to process each new Web account. Providers who currently have a Web interChange account and password do not need an additional account and password.

- New providers who wish to use the 837P transaction must complete, submit, and obtain **prior approval** of their vendor's software, trading partner ID, login ID, and password. Providers should allow one week to process vendor and account information. Providers may obtain instructions for account setup by obtaining a copy of the *Companion Guide – 837 Professional Claims and Encounters Transaction* on the IHCP Web site at http://www.indianamedicaid.com.
  - Providers who currently send claims using the 837P transaction are not required to make a second application.

- Providers must submit a claim for each service instance. Services cannot be combined with other non-PASRR service type(s), even if the service(s) are rendered on the same day, or same visit. For example, a claim for PASRR services cannot be combined with a claim for Medicaid services.

- PASRR claims are subject to all edits and audits not excluded by PASRR program requirements. If a claim encounters an edit or audit for missing or invalid information, the claim suspends or denies.

- Provider reimbursement for rendered services is determined by the procedure codes, modifiers, and the associated maximum (max) fee rate. Procedure code(s), modifier(s), and max fee rate(s) must accompany all PASRR claim submissions. Table 1 provides additional information.
- Providers are responsible for entering billable charges per the published procedure code and max fee rate.
- Procedure code(s) and modifier(s) must accompany all claim submissions. The system will capture as many as four modifiers for all PASRR claims with **MI** or **MR** segments. If the procedure code or applicable modifier is missing or invalid, edits will deny or suspend claims.
- Providers may void or replace PASRR claims.
- PASRR financial information is available on the 835 RA transaction.
- PASRR claims processing information will be reflected on the 276/277 Claim Status Request Response Transactions. Providers will be able to inquire on the claims status request and response using Web interChange.

Voids and Replacements

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

Web interChange Overview

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

The following are some of the features of Web interChange:

- *Claims Inquiry* allows providers to inquire about previously submitted claims – even before they make it to the RA summary or transaction. When EDS receives claims electronically through Web interChange, they are accessible within two hours and remain accessible for three years. Providers may search for claims using a date range, claim type, member ID, or ICN. When the basic claim information displays in Web interChange, the provider clicks the desired claim for more detail. To meet CMS HIPAA privacy requirements, built-in security features only allow billing providers to view the claims that they submit.
- *Eligibility Inquiry* (coming in the future) will allow providers to inquire about member eligibility using the member's PASRR ID number, Social Security Number, Medicare number, or name and date of birth. The response will provide the same information a provider obtains from the Automated Voice-Response (AVR) or the OMNI swipe card system.
- *Claim Submission* allows providers to submit PASRR claims electronically to the IHCP. **PASRR claims are a professional claim type**.
- *Check Inquiry* allows the provider to inquire about previously received payments. The provider can find checks or electronic funds transfers (EFTs) by searching within a date range or by a specific check number. Basic check information displays and the provider clicks on that line to obtain a list

of all claims associated with that check. Built-in security features allow only the billing provider to view the checks they have received.

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

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

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

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

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

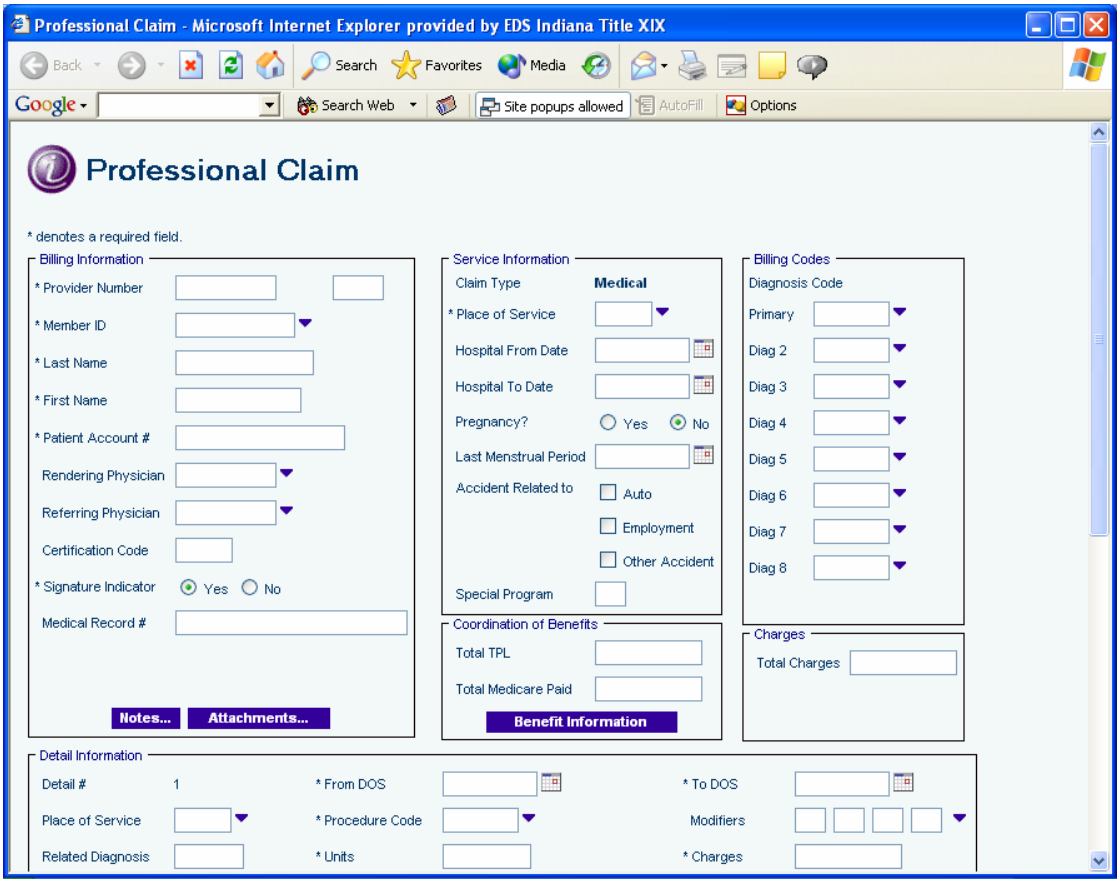

Figure 1 –Web interChange Claim Submission Window

Web Claim Print

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

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

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

837 Professional Claims and Encounters (837P) Transaction

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

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

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

Remittance Advice

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

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

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

Table 1– Local Code Crosswalk Procedure Codes, Modifiers And Max Fee Rates

Local Code	Local Code Description	Replacement Code	Crosswalked National Code and Modifiers	Rate
9075	Level II PAS-MR	T2011 U1 UA	**T2011**: Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per Evaluation **U1**: PAS (Preadmission Screening) **UA**: Mental Retardation / Developmental Disability	Max Fee $355.00
9076	Level II PAS-MR Psych Exam	T2011 U1 UA H1	**T2011**: Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per Evaluation **U1**: PAS (Preadmission Screening) **UA**: Mental Retardation / Developmental Disability **HI**: Integrated Mental Health and Mental Retardation / Developmental Disabilities Program	Max Fee $150.00
9077	Level II RR-MR	T2011 U2 UA	**T2011**: Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per Evaluation **U2**: RR (Resident Review) **UA**: Mental Retardation / Developmental Disability	Max Fee $355.00
9082	Level II RR-MR Psych Exam	T2011 U2 UA H1	**T2011**: Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per Evaluation **U2**: RR (Resident Review) **UA**: Mental Retardation / Developmental Disability **HI**: Integrated Mental Health and Mental Retardation / Developmental Disabilities Program	Max Fee $150.00
9079	Level II PAS-MI Initial	T2011 U1 UB	**T2011**: Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per Evaluation **U1**: PAS (Preadmission Screening) **UB**: Mental Illness	Max Fee $322.00
9080	Level II PAS-MI Initial Update	T2011 U1 UB TS	**T2011**: Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per Evaluation **U1**: PAS (Preadmission Screening) **UB**: Mental Illness **TS**: Follow-up service	Max Fee $143.50
9081	Level II RR-MI	T2011 U2 UB	**T2011**: Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per Evaluation **U2**: RR (Resident Review) **UB**: Mental Illness	Max Fee $322.00

Notes:

1. U1, U2, UA, and UB modifiers would be assigned by the Medicaid Program

2. HI and TS modifiers are existing national modifiers

CMS-1500 Claim Form Requirements

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

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

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

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

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

Please complete the sections as indicated in Table 2 for PASRR claims.

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for PASRR	
		Yes	No
1	**INSURANCE CARRIER SELECTION** – Mark Medicaid. **Required**.	X	
1a	**INSURED'S I.D. NUMBER** (FOR PROGRAM IN ITEM 1) – Provide the PASRR member identification number. Must be 12 digits (**800** + Social Security Number (SSN)). **Required.**	X	
2	**PATIENT'S NAME** (Last Name, First Name, Middle Initial) – Provide the member's last name, first name, and middle initial. **Required**.	X	
3	PATIENT'S BIRTH DATE – Provide the member's birth date in MMDDYY format. Optional. SEX – Mark the appropriate box. Optional.		X
4	INSURED'S NAME (Last Name, First Name, Middle Initial) – Not applicable. The IHCP member is always the insured.		X
5	PATIENT'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE (include Area Code) – Provide the member's complete address information. Optional.		X
6	PATIENT RELATIONSHIP TO INSURED – Not applicable.		X
7	INSURED'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE (INCLUDE AREA CODE) – Not applicable.		X
8	PATIENT STATUS – Mark the appropriate box. Optional.		X
Fields 9 and 9a–9d indicate policyholder information for individuals other than the member, such as another person who is court ordered to provide insurance for the member. These fields also provide additional member insurance information for members with more policies than field 11 and fields 11a through 11d can accommodate. ***Fields 9 and 9a – 9d do not apply to PASRR Billing.*** ***Fields 10 and 10a – 10d do not apply to PASRR Billing.***			
9	**OTHER INSURED'S NAME** (Last Name, First Name, Middle Initial) – If other insurance is available, and the policyholder is other than the member shown in fields 1a and 2, provide the policyholder's name**. Required, if applicable.**		X

(Continued)

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for PASRR	
		Yes	No
9a	**OTHER INSURED'S POLICY OR GROUP NUMBER** – If other insurance is available, and the policyholder is other than the member noted in fields 1a and 2, provide the policy and group number. **Required, if applicable**.		X
9b	**OTHER INSURED'S DATE OF BIRTH** – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, provide the requested policyholder birth date in MMDDYY format. **Required, if applicable**. **SEX** – Mark the appropriate box. Optional.		X
9c	**EMPLOYER'S NAME OR SCHOOL NAME** – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, provide the requested policyholder information. **Required, if applicable**.		X
9d	**INSURANCE PLAN NAME OR PROGRAM NAME** – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, provide the policyholder's insurance plan name or program name information. **Required, if applicable.**		X
10	**IS PATIENT'S CONDITION RELATED TO** – Mark the appropriate box in each of the four categories. This information is needed for follow-up third party recovery actions**. Required, if applicable**.		X
10a	**EMPLOYMENT?** (CURRENT OR PREVIOUS) – Mark **Yes** or **No**. **Required, if applicable**.		X
10b	**AUTO ACCIDENT?** – Mark **Yes** or **No**. **Required, if applicable**. **PLACE (State)** – Use the two-character state code. **Required, if applicable**.		X
10c	**OTHER ACCIDENT?** – Mark **Yes** or **No**. **Required, if applicable**.		X
10d	RESERVED FOR LOCAL USE – Not applicable.		X
Fields 11 and 11a through 11c provide member insurance information. ***Fields 11 and 11a through 11d do not apply to PASRR billing***			
11	**INSURED'S POLICY GROUP OR FECA NUMBER** – Provide the member's policy and group number of the other insurance. **Required, if applicable**.		X
11a	**INSURED'S DATE OF BIRTH** – Provide the member's birth date in MMDDYY format. **Required, if applicable. SEX** – Mark the appropriate box. **Required, if applicable**.		X
11b	**EMPLOYER'S NAME OR SCHOOL NAME** – Provide the requested member information**. Required, if applicable.**		X
11c	**INSURANCE PLAN NAME OR PROGRAM NAME** – Provide the member's insurance plan name or program name. **Required, if applicable.**		X
11d	**IS THERE ANOTHER HEALTH BENEFIT PLAN?** Mark **Yes** or **No**. If the response is *Yes*, complete Fields 9a–9d**. Required, if applicable**.		X
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – Use this field for Claim Note Text. 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.		X
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – Not applicable.		X

(Continued)

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for PASRR	
		Yes	No
14	**DATE OF CURRENT ILLNESS** (First symptom date) **OR INJURY** (Accident date) **OR PREGNANCY** (**LMP** date) – Use the date of the last menstrual period for pregnancy related services in MMDDYY format. **Required, if applicable.**		X
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, PROVIDE FIRST DATE – Not applicable.		X
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** – If Field 10a is *Yes* provide the applicable FROM and TO dates in a MMDDYY format. **Required, if applicable**.		X
17	**NAME OF REFERRING PHYSICIAN OR OTHER SOURCE** – Provide the name of the referring physician (including the primary physician of a lock-in or restricted card member), case manager for Waiver related services, or 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**.**		X
17a	**I.D. NUMBER OF REFERRING PHYSICIAN** – Use the IHCP provider number of the referring physician (including the primary physician of a lock-in or restricted card member), case manager for Waiver related services, or 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.		X
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** – Provide the requested FROM and TO dates in MMDDYY format. **Required, if applicable**.		X
19	**RESERVED FOR LOCAL USE** – Use the Hoosier Healthwise or *Medicaid Select* PMP two-digit alphanumeric certification code. **Required for Prime*Step* PCCM members**.		X
20	OUTSIDE LAB? – Mark the appropriate box. Optional. $CHARGES – Eight-digit numeric field. Optional.		X
21.1–21.4	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** – Complete Fields 21.1, 21.2, 21.3, and 21.4. Use the ICD-9-CM diagnosis codes in priority order. Four codes are allowed. At least one diagnosis code is required for all claims except claims for Waiver, transportation, and medical equipment/supply services.		X
22	MEDICAID RESUBMISSION CODE, ORIGINAL REF. NO. – Not applicable. For crossover claims, the combined total of the Medicare coinsurance, deductible, and psych reduction must be reported on the left hand side of field 22 under the heading *Code*. The Medicare paid amount (actual dollars received from Medicare) must be submitted in field 22 on the right hand side under the heading *Original Ref No*.		X
23	***PRIOR AUTHORIZATION*** NUMBER – The ***prior authorization*** (PA) number is not required, but use is recommended to track services that require PA. Optional.		X

(Continued)

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for PASRR	
		Yes	No
Date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. For services requiring authorization, the FROM date of service cannot be prior to the date the service was authorized. The TO date of service cannot exceed the date the specific service was terminated. For multiple services over a span of time, which apply to the same procedure code, the following apply: If the dates of service are consecutive, for example, one service per day, the FROM and TO dates of service can include the span of time with respective service units indicated in field 24g. *Example – One unit of service per day for five days is submitted FROM 100102 TO 100502 for five units.* If the dates of service are non-consecutive, each date of service is indicated on a separate line. *Example – one service on each of the following days: 100102, 100502, 100602, and 101502 are not submitted FROM 100102 TO 101502. Rather, 100102 and 101502 are submitted on individual service lines with one unit of service each and 100502 through 100602 are submitted with two units of service on the same line.*			
24A	**DATE OF SERVICE** – Provide the FROM and TO dates in MMDDYY format. Up to six date ranges are allowed per form. **Required.**	X	
24B	**Place of Service** – Use the POS code for the facility where services were rendered**. Required.** For a complete listing of POS codes, see http://cms.hhs.gov/states/poshome.asp or Table 3.	X	
24C	Type of Service – Not applicable.		X
24D	**PROCEDURES, SERVICES, OR SUPPLIES**	X	
	CPT/HCPCS – Use the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line. **Required**.	X	
	MODIFIER – Use the appropriate modifier, if applicable. Up to four modifiers are allowed for each procedure code. **Required, if applicable**.	X	
24E	**DIAGNOSIS CODE** – Use number 1 through 4 corresponding to the applicable diagnosis codes in field 21.1 through 21.4. A minimum of one and a maximum of four diagnosis code references are allowed on each line**. Required.**		X
24F	**$ CHARGES** – Provide the total amount charged for the procedure performed, based on the number of units indicated in field 24G. The charged amount is the sum of the total units multiplied by the single unit charge. Each line is computed independently of other lines. This is an eight-digit field. **Required.**	X	
24G	**DAYS OR UNITS** – Provide the number of units being claimed for the procedure code. Six digits are allowed, and 9999.99 units is the maximum that can be submitted (must be 1 for PASRR). **Required.**	X	
24H	**EPSDT Family Plan** – If the patient is pregnant, indicate with a **P** in this field on each applicable line. **Required, if applicable**.		X
24I	**EMG** – Emergency indicator. This field indicates services were for emergency care for service lines with a CPT/HCPCS code in field 24D. Indicate **Y** for yes or **N** for no. **Required, if applicable.**		X
24J	COB – Not Applicable (Used for EPSDT)		X

(Continued)

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation	Complete for PASRR	
		Yes	No
24K	**RESERVED FOR LOCAL USE** – Provide the rendering provider number of the group member, or the sole proprietor number. The entire nine-digit number and one alphabetic character location code must be used. If billing for case management, the case manager's number must be entered here. If billing for mid-level practitioners, the supervising physician's number must be entered here. **Required.**	X	
25	FEDERAL TAX I.D. NUMBER – Not applicable.		X
26	**PATIENT'S ACCOUNT NO**.. – Provide the internal patient tracking number. **Required**.	X	
27	ACCEPT ASSIGNMENT? – The IHCP provider agreement includes details about accepting payment for services. Optional.		X
28	**TOTAL CHARGE** – Provide the total of all service line charges in column 24F. This is an eight-digit field, such as 999999.99. **Required.**	X	
29	**AMOUNT PAID** – Provide payment amounts received from any commercial insurance source. All applicable items are combined and the total provided in this field. This is an eight-digit field. **Required, if applicable.** Other insurance – Provide the amount paid by the other insurer. If the other insurer was billed but paid zero, use **0** in this field. Attach denials to the claim form when submitting the claim for adjudication. Spend-down members – Attach the DPW form 8A to the claim form when submitting the claim adjudication. No deductible amount should be placed in this field.	X	
30	**BALANCE DUE** – Field 28, TOTAL CHARGE minus (–) field 29, AMOUNT PAID (by commercial insurance) equals (=) field 30, BALANCE DUE. This is an eight-digit field, such as 999999.99 **Required.**	X	
31	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS** – An authorized person, someone designated by the agency or organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not. **Required, unless the *Signature on File* form has been completed and is included in the provider enrollment file.** **DATE** – Provide the date the claim was filed. **Required.**	X	
32	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED, if other than home or office. Indicate the provider's name and address. This field is optional, but helps EDS contact the provider if necessary. Optional.	X	
	All providers in Indiana are issued a unique, individual provider number. Providers associated with a group must have an individual provider number tied to the group provider number. Use the rendering provider number of the group member or sole proprietor number in field 24K. Use the billing number for the group in field 33. *Providers not associated with a group (sole proprietors) should use the unique, individual provider number, in fields 32, without the alpha character, and in field 33, with the alpha character, to indicate the service location.*	X	
33	**PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE #** – Use the nine numeric and one alpha character billing provider number. If this claim is for a group practice, only the IHCP group provider number should be indicated in this field. **Required**. **Note: Only one IHCP provider number should be indicated in this field.**	X	

PASRR providers must use the appropriate place of service code as listed in Table 3.

Table 3 – Place of Service Codes

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

(Continued)

Table 3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service