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

To: First Steps Providers

Subject: First Steps Update Information

Overview

This bulletin provides additional information about the change in First Steps (FS) processors as outlined in *BT200602* dated February 3, 2006.

New Provider Letters

Beginning February 1, 2006, EDS became the processor for FS claims. The conversion of the previous contractor's data was successfully completed and EDS now maintains the physical files that belonged to the previous contractor. There are some data conversion issues, and EDS is restructuring the data files to resolve these issues. After this process is complete, providers will receive new provider letters. A provider's FS provider number will not change. The new letters will contain the historical data found in the original letter because this information may be necessary to help facilitate prior claim adjudication.

Service Matrix Information

Prior to receiving your new letter, review and make any enrollment changes through the Indiana First Steps Service Matrix. Review your tax identification number, demographics, and all payees linked to your group. The Web site for the Service Matrix can be found at https://www.infirststeps.com/matrix/default.asp. To update information with EDS, access the *Provider Update Application* at https://www.infirststeps.com/matrix/docs/maintenPDFs/UpdateForm.pdf. Print the form, complete it, sign it, and mail it to the following address:

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

In the future, EDS will enable providers to consolidate Indiana Health Coverage Programs (IHCP) and FS provider numbers. More information about this consolidation process will be published when it is available.

Credentialing and Recredentialing

Credentialing due dates are extended through May 1, 2006. This is an approved extension and grace period of the credentialing dates for FS providers that did not receive credentialing or recredentialing approval from the previous contractor.

The EDS Provider Enrollment Unit is analyzing the extended provider credentialing files and submitting requests to providers for additional documentation to complete those files.

Provider Credentialing and Recredentialing Process

Providers are required to do credentialing and recredentialing as delineated in the *Indiana's Early Intervention Personnel Guide (March 2006)*. EDS does not prepare credentialing information. The credentialing forms are located in the *Indiana's Early Intervention Personnel Guide (March 2006)* which can be downloaded from the FS Web site at https://www.infirststeps.com/matrix/docs/pdfs/ TR368_PersonnelGuide.pdf.

EDS reviews completed credentialing information, and approves in accordance with guidelines presented in the *Indiana's Early Intervention Personnel Guide (March 2006)*. EDS sends an approval letter with a certificate and provides the next recredentialing due date. Documents that are incomplete are returned to the provider with an explanation.

Claims Submissions

FS claims must only be submitted electronically. Providers may submit claims using Web interChange or the batch 837P transaction.

Web interChange

Providers who want to submit claims, view claim status, view prior authorizations (PA), or view check inquiry may use Web interChange. Web interChange is free, secure, and easy to use. To obtain a user ID and password for Web interChange, providers must submit an *Administrator Access Request Form* and authorization letter. This form is available at https://interchange.indianamedicaid.com. Click on **How To Obtain An ID**. The FS provider's billing and rendering provider numbers must be included on the form.

Claim submission using Web interChange is easy and fast. FS providers may enter and submit one claim at a time using the medical claim form. Refer to the *First Steps Provider Billing Information Quick Reference*, Attachment 1 of this bulletin, for detailed information about required claim submission information. This document is also available on the FS Web site at https://www.infirststeps.com/matrix/docs/docindex.asp. The attachments to this bulletin are found under the *Miscellaneous Documents* heading on the **Provider Enrollment** page.

To bill for multiple procedures for the same member on the same claim, create multiple details on the claim. After entering the required claim information on the claim form, save and submit the information. When the claim is submitted, an internal control number (ICN) is assigned for tracking the claim. The claim may also be printed..

Additional information about submitting claims is available on the Web interChange Web site by selecting **Help** and then click **Claim Submission Help**. Information is available for copying claims, voiding and replacing claims, and printing claims.

Approximately two hours after claim submission, the status of the claim can be checked by selecting **Claim Inquiry** in Web interChange. To inquire about submitted claims, the group provider number and service location code must be used. Claim information on Web interChange is retained and viewable for seven years. Providers may print claim status information from Web interChange. Additional information about how to use *Claim Inquiry* is available by selecting **Help** in Web interChange.

FS providers can also view PA information by choosing **PA Inquiry** on Web interChange. The PA search must include the rendering provider number (no service location code) and the member ID (RID) number. All authorizations converted from the previous processor (prior to February 1, 2006) display the authorization number, the procedure code, and the date range for the authorization. All authorizations entered on or after February 1, 2006, display the authorizations by frequency of the authorization and the number of units and dollars authorized. When claims pay against authorizations, the number of units and dollars used reflects in the number of units and dollars remaining for the authorization.

Use the **Check Inquiry** function of Web interChange to view checkwrite information for FS. The group provider number and service location code must be used for the check inquiry search. The search results display the electronic funds transfer (EFT) number and the total amount of payment. The check details page displays the basic check information and the ICN number, amount paid, and claim type for each claim associated with the payment. Additional information about how to use *Check Inquiry* is available by selecting **Help** in Web interChange.

Contact information for assistance with Web interChange, claim denial, and PAs is located in the *Contact Information* section of this bulletin.

Batch Claim Submission Using the 837P Transaction

FS providers can submit batch claims (multiple claims formatted and submitted in a batch form) using a software vendor who has been approved for submitting the HIPAA-compliant 837P transactions for FS claims. EDS is testing and approving several software vendors for batch FS claim submission.

Providers who wish to submit claims in batch form must select an approved vendor, then submit an IHCP Trading Partner Profile and *IHCP Trading Partner Agreement* to EDS. The IHCP Trading Partner Profile is completed and submitted on line. The *IHCP Trading Partner Agreement* must be printed, completed, signed, and mailed to the following address:

> **EDS**
> **Trading Partner Agreement**
> **950 N. Meridian St., 10th Floor**
> **Indianapolis, IN 46204**

These forms are located on the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/EDI_index.asp.

Providers who use batch claim submission to submit claims can view the status of their claims and view PA through Web interChange. Refer to the Web interChange section of this bulletin for information about obtaining login credentials for Web interChange.

Contact information for assistance with batch claim submission or the list of approved software vendors is located in the *Contact Information* section of this bulletin.

Provider Enrollment Process

The FS provider enrollment process has not changed. The following details are the enrollment process:

• The provider must complete the orientation classes prior to enrolling.

- After being accepted into the FS program, the provider may apply for a provider number which allows for claims submissions.

- *First Steps/Indiana Health Coverage Programs (IHCP) Provider Enrollment Application* and checklists can be downloaded from FS Web site at https://www.infirststeps.com/matrix/docs/enrollment.asp. The application must be completed and mailed with all the required documents as listed on the provider's applicable checklist. The completed documents must be signed and mailed to the following address:

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

- EDS sends the provider an acceptance letter containing individual provider numbers, a group provider number, where applicable, and demographic information.

- If an application is denied, it is returned with an explanation.

Reading the Remittance Advice

Reading the Remittance Advice, Attachment 2 of this bulletin, contains information for reading the weekly remittance advice (RA). The information outlined in Attachment 2 applies to all entities filing claims with EDS.

Providers should direct questions about RAs to EDS.

IHCP E-Mail Notifications Program

On January 17, 2006, EDS and the IHCP launched the IHCP E-Mail Notifications program. This program automatically issues e-mails to subscribers when IHCP publications and announcements are posted to the IHCP Web site.

This service is **free** and available to both providers and non-providers. It is possible to have multiple subscriptions to provide notifications at office, home, or to other e-mail addresses for associates and staff. To subscribe to the service, visit the IHCP Web site at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.

On the *IHCP E-mail Notifications* page, click the **Open New Account** button, complete the profile information, and select the publications for e-mail notifications. You will receive a *Subscription Request* e-mail with instructions and a link to activate your subscription. You must follow the link in the e-mail to activate your registration. Once your subscription is activated you will receive a *Welcome!* e-mail to verify the activation. You may subscribe or unsubscribe at any time. Each notification e-mail contains a link for updating your subscription profile or unsubscribing to the service.

Publications are posted to the Web site on Tuesdays and Thursdays of each week. For a period of time *both* e-mail notifications and paper copies of the publications will be provided.

Contact Information

For complete lists of contact information, refer to the *First Steps Provider Quick Reference* document included as Attachment 4 of this bulletin or the *Indiana Health Coverage Programs Quick Reference*

available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf.

The following is contact information pertinent to the topics covered in this bulletin.

For questions about your credentialing file, contact the Provider Enrollment Help Desk at 1-877-707-5750. The Provider Enrollment staff will work to resolve your credentialing issues.

If you are not enrolled as a FS provider or registered for orientation classes, you must download the *Registration Form* from the Indiana FS Web site at http://www.state.in.us/fssa/first_step/pdf/registration.pdf and send the completed registration form to the following address:

ProKids, Inc.
2511 E 46th Street
Suite E-1
Indianapolis, IN 46205

> *EDS **does not** process FS registration forms, and if delivered to the EDS address the packet will be returned to the sender unprocessed.*

To obtain enrollment information, contact the Provider Enrollment Help Desk at 1-877-707-5750.

For technical assistance with Web interChange, contact the EDI Solutions Help Desk at (317) 488-5160 in the Indianapolis local area, or 1-877-877-5182, or by e-mail at INXIXElectronicSolution@eds.com. When calling the EDI Solutions Help Desk, select option 2 for Web interChange or option 3 for FS.

For assistance with claim denial or PAs, contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278.

For assistance with batch claim submission or for a list of approved software vendors for FS claim submission, contact the EDI Solutions Help Desk at (317) 488-5160 in the Indianapolis local area, or 1-877-877-5182, or by e-mail at INXIXTradingPartner@eds.com.

Additional contact information is available from the *First Steps Provider Quick Reference* included as Attachment 3 of this bulletin and available on the FS Web site at https://www.infirststeps.com/matrix/docs/docindex.asp. The attachments to this bulletin are found under the *Miscellaneous Documents* heading on the **Provider Enrollment** page.

First Steps
Provider Billing Information
Quick Reference

EDS

Overview

This document provides the field names and descriptions of the **required fields** for billing First Steps claims using Web interChange.

> Note: On Web interChange, prior authorization (PA) is linked to the rendering provider number, not the group number. If no PA appears on Web interChange, the provider should contact the intake or service coordinator.

Required Header Information

Table 1 – Required Header Information

Field	Description
Provider Number	• Enter the billing (payee) provider number in this field. • This is a nine-digit and one alpha character number (the alpha character is the location code). • A billing provider is defined as the payee at the service location. A billing provider can be a facility, group, clinic, or sole proprietor. • An example of a billing provider number is 200000000 A.
Member ID	• Enter the member (child) identification (RID) number in this field. • The member ID is a 12-digit numeric number. • The RID is the child ID number that is included in the IFSP or on the combined enrollment form. The child's in the First Steps Program will have a RID number that begins with 950. • An example of a First Steps RID number is 950120000000.
Last Name	Enter the member's last name as it appears on the IFSP.
First Name	Enter the member's first name as it appears on the IFSP.
Patient Account Number	• This is an alphanumeric field that is required by HIPAA regulations. • Providers must enter a number here. • This number can be the same for patients or it can be unique to each member.
Rendering Physician	• Enter the rendering provider number assigned by Provider Enrollment. This number was identified as the group member on the provider enrollment documentation received by each First Steps provider. • This number is nine digits and does not include an alpha character. • A rendering only provider is the provider that renders the service as an employee of a group or clinic. Rendering provider numbers are linked to the group number.

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Table 1 – Required Header Information

Field	Description
Note: Providers who are billing for the same rendering provider on the entire claim, may enter this information on the header of the claim and do not need to re-enter the information at the detail. However, if a provider is billing a claim for a child for services that were rendered by multiple rendering providers, then the rendering physician number must be left blank at the header of the claim and the appropriate rendering provider's information must be entered at the corresponding detail of the claim.	
Place of Service (POS)	• Enter the POS code for the facility where services were rendered. • All First Steps claims must include the proper POS. • POS is used to determine pricing for the claim. • If the POS is missing from the claim, the claim will deny. • New POS codes have been added to accommodate additional locations identifying where specific services were rendered. • POS 99 (other) is not a valid POS code. POS 99 will always be reimbursed the on-site rate. • Table 2 lists the additional POS codes that have been identified specifically for First Steps. • A complete list of POS codes can be found in the First Steps Provider Billing Manual located at https://www.infirststeps.com/matrix/docs/misc/FirstStepsProviderBillingManualPRFS10001V1.pdf

Table 2 – Place of Service Codes

Field	Description
03	Nursery School/Child Care Center
12	Home
22 or 11	Outpatient Service Facility
21	Hospital Inpatient
95	Family Day Care
96	Community Setting (playground, library, Children's Museum, and so forth)
97	EI Class/Program
98	Residential Facility

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Required Detail Information

Table 3 – Required Detail Information

Field	Description
From/To DOS	• Enter the From and To dates of service (DOS) in CCYYMMDD format for the billing period for each service rendered. • The From and To DOS are always the same date.
Note: When billing DOS for service coordination, bill one DOS on the detail. Providers must use the last date of contact with the family as the DOS or the last day of the month as the DOS on the claim, either is acceptable. Providers must not span any DOS on the claim. Web interChange will be modified to prevent providers from billing date spans on the claim.	
Place of Service	• If the POS was entered at the header of the claim, then it is not necessary to enter it again. • If the information was not entered at the header of the claim, See *Required Header Information* for guidelines on submitting the proper POS code for a claim.
Procedure Code	• Enter the appropriate Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) code in this field. • Only enter one procedure code on each claim form service line. • For updated code information, providers should refer to the CPT code crosswalk available on the provider matrix at https://www.infirststeps.com/matrix/docs/docindex.asp. A code set has been developed for each service type that crosswalks old local codes to the new CPT/HCPCS codes.
Modifiers	• Enter the appropriate modifier in this field. • As many as four modifiers are allowed for each procedure code. • All First Steps procedures require use of modifier *TL* (early intervention). • Providers should access the First Steps code set for their provider specialty to determine if additional modifiers are required. Code sets are available at https://www.infirststeps.com/matrix/docs/docindex.asp. • Additional modifiers that may be used for First Steps billing include: 　– *Modifier 52 – Reduced Services.* This modifier is used for services that are rendered in minutes. 　– *Modifier HQ – Group Setting.* This modifier is used for services that are rendered in a group setting. A group setting is defined as services rendered to multiple members at the same time

(Continued)

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Table 3 – Required Detail Information

Field	Description
Units	• Enter the number of units being claimed for the procedure code in this field.
	• When billing for services that are rendered in minutes, then one unit equals 15 minutes.
	• Additional information about billing units can be found in the First Steps Provider Billing Manual located at https://www.infirststeps.com/matrix/docs/misc/ FirstStepsProviderBillingManualPRFS10001V1.pdf
Note: When billing for Service Coordination, providers must always bill one unit in the Units field on Web interChange when billing for procedure codes G9005 TL (2 contacts), G9009 TL (3 contacts), and G9010 TL (4 contacts). The description for each of these procedure codes includes the number of contacts that were rendered to a member, therefore, there is no need to identify the number of contacts in the units field on the claim.	
Charges	• Enter the total amount charged for the procedure performed. This amount is based on the number of units included in the Units field.
	• The charged amount is the sum of the total units multiplied by the single unit charge. Each line is computed independently of other lines.
Rendering Provider	• If the rendering provider number was entered at the header portion of the claim, then it is not necessary to enter it again.
	• If the information was not entered at the header portion of the claim, please indicate the rendering provider in this field. See *Required Header Information* for the description of how to enter rendering provider information.
Taxonomy	• The taxonomy code is structured into the following three distinct levels: – Provider type – Classification – Area of specialization
	• Providers may determine their taxonomy code from the provider matrix at https://www.infirststeps.com, and selecting **Service Matrix**, **Provider Enrollment** (or directly at https://www.infirststeps.com/matrix/docs/docindex.asp), and selecting the appropriate First Steps Code Sheet. A code sheet has been developed for each service type.

Contact Information

For additional information about claims and billing, contact the EDI Solutions Help Desk at (317) 488-5160 in the Indianapolis local area, or 1-877-877-5182.

First Steps
Reading the Remittance Advice

General Information

Providers receive a weekly RA statement about the status of processed claims. All providers receive the paper RAs at this time. Providers who wish to receive their RA information electronically are required to complete the necessary trading partner profiles and agreements for receipt of the electronic 835 transaction. RAs provide information about adjudicated claims that are paid, denied, or adjusted. Paper RAs include in-process claim data. The claims in process section of the paper RA lists suspended claims, claims that generate a claim correction form (CCF), and claims in the adjustment cycle. The paper RA also provides information about other processed financial transactions. Additionally, CCFs are mailed with the paper RA statement and banner page.

The banner page conveys important information about program changes and upcoming training sessions. The banner page should be shared with the staff responsible for filing and posting claims. The RA only reports claim activity for each specific week. Providers who do not receive an RA do not receive the banner page messages for that same week; however, all banner pages can be accessed via the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/banner_results.asp.

The RA is an important provider payment and claim-tracking device. Claim transactions should be reconciled as soon as possible after receiving the RA statement. CCFs must be completed and returned to EDS within 45 days of receipt by the provider.

The *First Steps Provider Billing Manual* is available on the First Steps Web site at https://www.infirststeps.com/matrix/docs/misc/FirstStepsProviderBillingManualPRFS10001V1.pdf

Remittance Advice Field Definitions

Table 1 lists each of the fields shown on a paper RA and a description of the information contained. A numeric digit precedes each description. The numeric digit corresponds to fields in Figures 1 – 7. The RA field definitions in Table 1 are in alphabetic order by *Field Name*:

> Note: Not all fields appear on each section of the RA. Many fields are specific to the claim type being billed.

Table1 – Provider Remittance Advice Definitions

Field Name	Description/Definition
1 ADMIT DATE	This does not apply to First Steps.
2 ALLOWED AMOUNT or ALWD AMT or ALLOWED	This field is not used after December 2, 2003.
3 AR NUMBER	This is the AR number assigned during processing. This is either the adjustment ICN, if the AR is a result of an adjustment transaction, or a user-assigned number, if the AR was manually established.
4 BALANCE	This is the remaining balance of the AR offset **after** the current weekly financial cycle.

(Continued)

First Steps
Reading the Remittance Advice

Table1 – Provider Remittance Advice Definitions

Field Name	Description/Definition
5 BILLED AMOUNT or BILLED AMT	This is the total dollar amount requested by the provider for the services billed on the claim, as well as for each detail line. This does not include overhead on home health claims.
6 CAPITAL	This does not apply to First Steps.
7 CCN	Cash control number. This is a unique number associated with a cash receipt. This number is used when a provider has submitted a refund in error or has over-refunded an amount.
8 CHECK/EFT NUMBER	If a check was generated, the check number is listed. If the provider is an EFT participant, this is the control number of the EFT transaction.
9 CO-PAY	This does not apply to First Steps.
10 DATE SVC PERF	This is the date the specific service was actually provided.
11 DAYS/UNITS	This indicates the number of days or units billed.
12 DED AMOUNT or DED	This does not apply to First Steps.
13 DISPENSE DATE	This is the date a drug was actually dispensed to the member. It is also known as the service date.
14 DSH	N/A
15 EOBs or EOB CODES or HEADER EOBS or DETAIL EOBs	These are the EOB codes used to explain the processing results of a particular claim. HEADER EOBs apply to the main body of the claim, while DETAIL EOBs apply to a specific claim service line. Some RAs show header (claim level) EOB information as EOB 000 and detail EOB information as EOB 001, EOB 002, EOB 003, and so forth. The EOBs have been reordered to begin with the lowest code and end with the largest code.
16 HCPCS/RATE	This is the Healthcare Common Procedure Coding System (HCPCS) code or the unit rate for the services indicated by the corresponding REV CD.
17 ICN	This is the unique internal control number (ICN) assigned to identify and track a claim.
18 LIAB	This does not apply to First Steps.
19 LOCATION CODE	This is the single, alphabetic code used to identify the location of the billing provider.
20 MED ED	This does not apply to First Steps.
21 MEDICAID ALLOWED	This does not apply to First Steps.
22 MEDICAID BILLED	This does not apply to First Steps.
23 MEDICAID PAID	This does not apply to First Steps.

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Table1 – Provider Remittance Advice Definitions

Field Name	Description/Definition
24 MEDICARE PAID	This does not apply to First Steps.
25 MODIFIERS	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be returned on each detail line and could occur 50 times per claim depending on the number of detail lines billed.
26 NDC	This does not apply to First Steps.
27 NET ADJUSTED PAYMENT OR OVERPAYMENT (REFUND)	This amount is the net result of an adjustment. If the original claim paid is more than the adjusted claim, this is a negative amount.
28 ORIGINAL AMOUNT	This is the original amount of an AR that was established.
29 ORIGINAL ICN	This is the original ICN, if the AR action is the result of a claim-specific adjustment.
30 OUTLIER	This does not apply to First Steps.
31 OVRHD AMOUNT	This does not apply to First Steps.
32 PAID AMOUNT	This is the net dollar amount paid for the services rendered, reflecting the billed amount reduced or increased by all adjustments, including the TPL AMOUNT, COPAY, DED AMOUNT, or OVRHD AMOUNT.
33 PAT NO.	Returned on the RA. This is the unique patient number assigned by the provider and submitted on the original claim. This is usually used for internal tracking and control purposes. This field is 20 characters.
34 PAYOUT AMOUNT	This is the amount of the payout transaction, the amount paid to the provider.
35 PL SERV	This is the place of service code and indicates where the services were rendered.
36 PROC CODE	This is the procedure code for services rendered.
37 PROVIDER NAME/ADDRESS	This is the name and address of the provider billing for services.
38 PROVIDER NUMBER	This is the number used to identify the provider billing for services.
39 QTY	This does not apply to First Steps.
40 REASON CODE	This is a code assigned to indicate why a payout action was taken, an AR was established, or a non-claim specific refund transaction was performed. This also generates an associated EOB code that briefly explains the action taken.
41 RECIPIENT NAME	This is the last name, first name, and middle initial of the member who received the service.

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Indianapolis, IN 46207-7263   *For more information visit www.infirststeps.com*

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First Steps
Reading the Remittance Advice

Table1 – Provider Remittance Advice Definitions

Field Name	Description/Definition
42 REFUND AMOUNT	This indicates a non-claim specific refund amount.
43 REFUND AMOUNT APPLIED	This shows any money returned by the provider to cover a negative adjustment such as a check-related adjustment.
44 REIMB METH	This does not apply to First Steps.
45 RENDERING PROVIDER	This is the unique First Steps provider identification number of the provider that rendered a particular service.
46 REV CD	N/A
47 RID NO.	This is the member's 12-digit First Steps identification number.
48 RX NO.	This does not apply to First Steps.
49 SERVICE DATES	This indicates the dates particular services were rendered.
50 FROM	This is the earliest service date on all the detail lines of a particular ICN.
51 THRU	This is the last service date on all the detail lines of a particular ICN.
52 SET UP DATE	This is the date an original AR was established.
53 SRV DATE	N/A
54 SURF	N/A
55 TOOTH	N/A
56 TPL AMOUNT or TPL AMT	This is the dollar amount paid for the services by any source outside of First Steps.
57 TRANSACTION NUMBER	This is the unique number assigned by Indiana*AIM* to identify a payout transaction.
58 UNITS	This is the number of units for the particular service rendered.
59 MEDICARE DEDUCTIBLE	This does not apply to First Steps.
60 MEDICARE CO-INSURANCE	This does not apply to First Steps.
61 TOTAL ADJUSTMENT PAYMENT	This amount is the net result of the adjustment. If the *mother* claim paid more than the *daughter* claim, this amount will be a negative amount. If the *daughter* claim paid more than the *mother* claim, this amount will be a positive amount.
62 DRG	This does not apply to First Steps.

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First Steps
Reading the Remittance Advice

Table1 – Provider Remittance Advice Definitions

Field Name	Description/Definition
63 ARCs or ADJUSTMENT REASON CODES or CLAIM LEVEL ARCS ARCs or SERVICE LINE LEVEL ARCS	These adjustment reason codes (ARCs) capture the dollars from claim processing that report the differences between the billed and the paid amounts. Claim level ARCs apply to the full claim and service line level ARCs apply to the specific details. Some RAs show header ARCs with the EOBs and remark codes as ARC 000 and the service line adjustments as ARC 001, ARC 002, EOB 003, and so forth. *Note that the ordering of these codes is by the first character.*
64 REMARKS or ADJUSTMENT REMARK CODES	These remarks are reported with ARCs only when they add information at the claim or service line level.
65 FIN ARC	This is the financial ARC from the 835 Implementation Guide (IG) internal code set that indicates the reason for the adjustment to net payment associated with the money related to the financial transaction.
66 DRG/LOC	This does not apply to First Steps.
67 CALC. PAYMENT	This does not apply to First Steps.
68 DTL PAID AMOUNT	Replaces allowed amount at the detail (service line) level.
69 MEDICAID DTL PAID AMOUNT	This is the net dollar amount paid for the services rendered at the detail level, reflecting the billed amount reduced or increased by all adjustments, including the TPL AMOUNT, COPAY, DED AMOUNT, or OVRHD AMOUNT.
70 DTL SUM AMOUNT	Sum of all detail amounts.

Explanation of Benefits Codes

Each paper RA includes EOB codes. EOB codes are not reported on the electronic 835 transaction. These codes and the corresponding narratives describe the reason claims suspended, denied, or were not paid in full. The EOB code is a four-digit number. Because the claim can have edits and audits at both the header and detail levels, EOB codes are listed for both header and detail information. A maximum of 20 EOBs are listed for the header, and a maximum of 20 EOBs are listed for each detail line. Exceptions are suspended claims, which have a maximum of two EOBs per header and per detail. The electronic RA does not contain these non-adjudicated claims. These are not denial codes, but rather the reason the claim is being reviewed. EOB data is listed immediately following the claim header and detail information beside the caption of the EOB on the paper RA. The header EOBs are listed under EOB 000, the EOBs for service line detail one of the claim are listed under EOB 001, and the EOBs for the second service line detail of the claim are listed under EOB 002. If there are no EOBs posted for a particular EOB XX line, the line does not print. A complete list of EOBs is located on the IHCP Web site at http://indianamedicaid.com/ihcp/ProviderServices/eob_frameset.htm. EOBs are considered local codes and are not transmitted in the electronic 835 transaction. Examples of EOB codes and narratives are listed in Table 2.

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Table 2 – Explanation of Benefit Codes

Code	Description	Provider Action Required
0000	Claim paid as billed	No action required
0001	Claim pended for examiner review	No action required. Follow the progress of the claim on the RA or use the automated voice-response (AVR) system
0002	CCF generated – waiting provider response	Return CCF within 45 days
0201	Billing provider's number is missing	Resubmit claim with nine-digit provider number
0203	Recipient ID number is missing	Resubmit claim with 12-digit member identification (RID) number
0256	This service is not payable, recipient spend down liability not met	Obtain 8A Form if spend-down met for date of service (DOS). Resubmit claim. If the spend-down has not been met on the DOS, bill the member for the outstanding balance
2014	The personal resource amount deducted from the claim was based on the amount reported by the county office of the member. An adjustment should not be filed until the resource amount is verified with the member's county caseworker	Verify the personal resource amount with the county office. When verified and corrected, return the Adjustment Request Form. When adjustment is complete, resubmit the claim
4033	The modifier used is not compatible with the procedure code billed	Refer to Current Procedural Terminology (CPT®) code manual and resubmit claim with correct modifier
6650	The number of services provided exceeds medical policy guidelines. This is a once-in-lifetime procedure	For billing policies and procedures, refer to the *First Steps Provider Billing Manual*.

Questions concerning EOB codes should be directed to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Adjustment Reason Codes

ARCs are provided with each claim or financial transaction included in a weekly RA. A complete list of claim-specific ARCs is available on the Washington Publishing Company Web site at http://www.wpc-edi.com/codes/. ARCs and their corresponding narratives describe the adjustment reason reported from each claim that adjudicated as denied, or not paid in the full amount as billed. The ARCs are alphanumeric codes from an external national code set used with the 835 Implementation Guide (IG) to report the associated dollars from the adjustment between the billed and the allowed or paid amount. Because the claim can process against edits and audits at both the claim (header) and service line (detail) levels, these ARCs can be reported for either service line and claim level or both. A maximum of 20 ARCs can be listed on the paper RA at the claim level, and a maximum of 20 ARCs can be listed for each service line. Exceptions are suspended claims, which have a maximum of two ARCs per claim level and per service line level. **These are not denial codes, but rather the reason the claim is being reviewed.** ARC

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data is listed immediately following the EOB at the claim level and service line beside the label of ARC on the paper RA. ARC 000 lists claim level reported codes. ARC 001 lists service line one of the claim's codes, and ARC 002 lists service line two of the claim's codes. If there are no ARCs posted for a particular service line detail, the line does not print. A complete list of claim-related ARCs is located on the Washington Publishing Company Web site at http://www.wpc-edi.com/codes/. Examples of claim level ARCs and narratives are listed in Table 3.

Table 3 – Adjustment Reason Code Examples

EOB	ARC	ARC Description	Remark
0201	16	Claim/service lacks information that is needed for adjudication.	M57 – Incomplete/invalid provider number
0203	16	Claim/service lacks information that is needed for adjudication. Additional information is supplied using remittance remark codes whenever appropriate.	M58 – Please resubmit the claim with the missing/correct information so that it may be processed.
0256	16	Claim/service lacks information that is needed for adjudication. Additional information is supplied using remittance remark codes whenever appropriate	No remark code available to further clarify
2014	142	Claim adjusted by the monthly Medicaid patient liability amount	N58 – Patient liability amount missing, invalid, or not on file.
4033	4	The procedure code is inconsistent with the modifier used or the required modifier is missing.	M58 – Please resubmit the claim with the missing/correct information so that it may be processed
6650	119	Benefit maximum for this time period has been reached	No remark code available to further clarify

Financial Adjustment Reason Codes

A complete list of financial transaction ARCs is available from the 835 IG located on the Washington Publishing Company Web site at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. The financial ARCs are two-character alphanumeric codes associated with financial transactions and activities that increase or decrease the net payment amount associated with the weekly RA. These ARCs are also reported on the ARC description page of the paper RA. These are not part of the claim-specific ARC code set. On the paper RA, these financial ARCs are reported on the financial page under the heading FIN ARC.

Adjustment Remark Codes

Adjustment remark codes are provided with each claim included in a weekly RA only when they add additional information to clarify the reason for the adjustment to payment reported with a claim-related ARC.

A complete list of claim-specific adjustment remark codes is available on the Washington Publishing Company Web site at http://www.wpc-edi.com/codes/. These remark codes are

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provided with the adjustment reason reported from each claim that adjudicated as denied, or not paid in the full amount as billed. The remark codes are alphanumeric codes from an external national code set used with the 835 IG that are used to report the associated dollars from the adjustment between the billed and the allowed or paid amount. Because the claim can process against edits and audits at both the claim (header) and/or service line (detail) levels, these remark codes can be listed for either service line and claim level or both. A maximum of 20 remarks can be listed at the claim level, and a maximum of 20 can be listed for each service line. Exceptions are suspended claims, which have a maximum of two remarks per claim level and per service line level. **These are not denial codes, but rather the reason the claim is being reviewed.** Remarks data is listed immediately following the ARCs at the claim level and service line beside the label of REMARKS on the paper RA. REMARK 000 lists claim level reported codes. REMARK 001 lists service line one of the claim's codes and REMARK 002 lists service line two of the claim's codes. If there are no remarks posted for a particular REMARK XX line, the line does not print. A complete list of claim-related remarks is located on the Washington Publishing Company Web site at http://www.wpc-edi.com/codes/.

> *Note: In the 835 electronic RA transaction, the remark codes are aggregated at the claim and service line level. Remark code descriptions are not printed in the code description section of the paper RA due to the length of the descriptions.*

Questions about the ARC or remark codes reported in claims processing should be directed to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. The complete code sets are available at the Washington Publishing Company Web site at http://www.wpc-edi.com/codes/.

Summary Page

The final page of the paper RA is the Summary Page. This page provides a complete accounting of claims processing and payment activity for the current cycle and year-to-date. Table 4 lists each of the fields and a description of the information contained in the field. Each description is preceded by an alphabetic code that corresponds to each field in Figure 8 for cross-reference.

Table 4 – Summary Page

Field	Description
A Claims Data	This section organizes the claims processed for this provider. Current information reflects counts and dollars for the current cycle as reflected on this RA. Year-to-date information reflects counts and dollars processed year-to-date for this provider, including the current cycle.
B Claims Paid	This is the number of paid claims processed. This is the total dollar amount paid for those claims.
C Claim Adjustments	This is the number of claims adjusted that resulted in increased payments. This is the additional dollar amount paid for the adjusted claims.
D Claim Interest	This is the amount of interest paid on clean electronic claims not processed within 21 days from receipt and clean paper claims not processed within 30 days from receipt.

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Table 4 – Summary Page

Field	Description
E Total Claims Payment	This is the total of claims paid, claims adjustment, and claim interest dollars. This ties to the claims payment line listed under earnings data.
F Claims Denied	This is the total number of claims denied for payment.
G Claims In Process	This is the total number of claims suspended for additional review.
H Earnings Data	This section provides the total amount paid to the provider and the total earnings reflected for the provider.
I Payments	This section provides the total amount paid to the provider. Current information reflects activity from this RA. Year-to-date information reflects total activity for this calendar year, including the activity specific to this RA.
J Claims Payments	This is the sum total of claims paid, claims adjusted, and claims interest dollars. This amount ties to the claims payment line listed under Claims Data.
K Managed Care Administrative Payment	This does not apply to First Steps.
L Hoosier Healthwise Capitation Payment	This does not apply to First Steps.
M System Payouts (Non-claim Specific)	This is the total amount of non-claim specific payments included in the RA checkwrite total.
N Accounts Receivable (Offsets)	This is the amount deducted from the RA checkwrite for outstanding ARs due to First Steps.
	Claim Specific – Offsets related to ARs tied to a specific claim or ARs with a control number that begins with 5.
	Current Cycle – Offsets related to adjustments reflected on the current RA.
	Outstanding From Previous Cycle – Offsets related to adjustments that were processed in prior cycles and recouped in the current cycle.
	Non-claim Specific – Offsets not related to a given claim, or ARs with a control number that begins with 60, not including those issued for financial reason code 8412 – Partial payment(s).
	Partial Payment(s) Recoveries (Partial Provider Payment or Repayment Agreement Recoveries) – Offset(s) related to partial provider payments due to an expenditure related to provider repayment agreements, or ARs with a control number begins with 60 and financial reason code 8412.
O Net Payment	This amount equals the total amount of the check if a payment is due, or is zero if the amount of offset is equal to the amount of payment due. The total is determined by adding claim payments, and system payouts, and then subtracting claim specific offsets, non-claim specific offsets, and partial payment(s) recoveries offsets.

(Continued)

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Table 4 – Summary Page

Field	Description
P Refunds	This amount reflects checks received for refunds due the program that were applied to the provider's earnings.
Q Claim Specific Adjustment Refunds	This amount is for checks received from a provider and applied to a given prior paid claim.
R Non-Claim Specific Refunds	This amount is for checks received and applied against the provider's earnings, but not tied to a given prior paid claim.
S Other Financial	This amount reflects other financial activity affecting the provider's earnings.
T Manual Payouts (Non-Claim Specific)	This amount reflects payments made to the provider outside of Indiana*AIM*, not included in any RA checkwrite total, but which must be included in total earnings.
U Voids	This amount reflects First Steps payment checks returned to EDS uncashed.
V Net Earnings	This is the net amount First Steps paid to the provider. This amount is calculated by adding the net payment and manual payouts, and then subtracting claim specific refunds, non-claim specific refunds, and voids. This is the total reported to the IRS on the 1099.
W Payments to Lien Holders	This amount details any payments made to lien holders that are deducted from the net payment made to the provider.

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```
Report: CRA-00113-W              INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION        Date: MMDDYYYY
Process:                              INDIANA HEALTH COVERAGE PROGRAMS                     Time: HH:MM:SS
Location:                                      SERVICED BY EDS                            Page: 99,999

                                             PROVIDER REMITTANCE ADVICE
                                                HCFA 1500 CLAIMS PAID
38 999999999 X 19
                                                                                  8 ECK/EFT NUMBER 999999999

37 1212 SOUTH SMITH STREET
P.O. BOX 30303
ANYTOWN, IN 99999-9999

41 RECIPIENT NAME   47 RID NO./      17 --ICN--         33 PAT NO./   49 SERVICE DATES  45 RENDERING   5 BILLED  68 DTL PAID  56 TPL      32 PAID
   XXXXXXXXXXX X X  35 PL SERV    36 PROC CD               58 UNITS      FROM   THRU      PROVIDER     AMOUNT    AMOUNT      AMOUNT   9 CO-  AMOUNT
                                25 MODIFIERS                                                                                           PAY
                   999999999999     RRYYJJJBBBSSS      999999999999   MMDDYY MMDDYY   9999999999X   999.99    999.99     999.99   99.99  999.99
                          XX     XXXXX XX XX XX XX         9999.99    MMDDYY MMDDYY   9999999999X   999.99    999.99     999.99   99.99  999.99
                          XX     XXXXX XX XX XX XX         9999.99    MMDDYY MMDDYY   9999999999X   999.99    999.99     999.99   99.99  999.99
                          XX     XXXXX XX XX XX XX         9999.99    MMDDYY MMDDYY   9999999999X   999.99    999.99     999.99   99.99  999.99
                          XX     XXXXX XX XX XX XX         9999.99    MMDDYY MMDDYY   9999999999X   999.99    999.99     999.99   99.99  999.99
                          XX     XXXXX XX XX XX XX         9999.99    MMDDYY MMDDYY   9999999999X   999.99    999.99     999.99   99.99  999.99


15 EOBS      000    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
             001    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
             002    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999

63 ARCS      000    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
             001    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
             002    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999

64 REMARKS   000    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
             001    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
             002    9999    9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
                                TOTAL HCFA 1500 CLAIMS PAID: 999,999.99 999,999.99 99,999.99 99.99 999,999.99
```

Figure 1 – Medical Claims Paid

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```
Report: CRA-0014-W              INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION        Date: MMDDYYYY
Process:                            INDIANA HEALTH COVERAGE PROGRAMS                     Time: HH:MM:SS
Location:                                   SERVICED BY EDS                              Page: 99,999

                                       PROVIDER REMITTANCE ADVICE
                                       HCFA 1500 CLAIMS DENIED

38 999999999 X  19
37 JONES MEDICAL CLINIC                                                      6 CHECK/EFT NUMBER 999999999
1212 SOUTH SMITH STREET
P.O. BOX 30303
ANYTOWN, IN 99999-9999

41 RECIPIENT NAME     47 RID NO./     17 --ICN--      33 PAT NO./     49 SERVICE DATES   45 RENDERING   55 BILLED    56 TPL
XXXXXXXXXXXX X X         35 PL SERV   36 PROC CD/25 MODIFIERS  58 UNITS      FROM THRU      PROVIDER     AMOUNT       AMOUNT
                     999999999999        RRYYJJJBBBSSS     XXXXXXXXXXX   MMDDYY  MMDDYY   9999999999X   999,999.99   99,999.99
                              XX     XXXXX XX XX XX XX       9999.99   MMDDYY  MMDDYY   9999999999X   999,999.99   99,999.99
                              XX     XXXXX XX XX XX XX       9999.99   MMDDYY  MMDDYY   9999999999X   999,999.99   99,999.99
                              XX     XXXXX XX XX XX XX       9999.99   MMDDYY  MMDDYY   9999999999X   999,999.99   99,999.99
                              XX     XXXXX XX XX XX XX       9999.99   MMDDYY  MMDDYY   9999999999X   999,999.99   99,999.99


15 EOBS     000    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999
            001    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999
            002    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

63 ARCS     000    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999
            001    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999
            002    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

64 REMARKS  000    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999
            001    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999
            002    9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999   9999
                         TOTAL HCFA 1500 CLAIMS DENIED: 999,999.99 999,999.99 99,999.99 99.99 999,999.99
```

Figure 2 – Medical Claims Denied

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Figure 3 – Medical Claims in Process

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```
Report: CRA-0016-W              INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION        Date: MMDDYYYY
Process:                                 INDIANA HEALTH COVERAGE PROGRAMS                 Time: HH:MM:SS
Location:                                      SERVICED BY EDS                            Page: 99,999

                                          PROVIDER REMITTANCE ADVICE
                                          HCFA 1500 CLAIM ADJUSTMENTS

38 999999999 X 19
37 JONES MEDICAL CLINIC                                                  8 CHECK/EFT NUMBER 999999999
1212 SOUTH SMITH STREET
P.O. BOX 30303
ANYTOWN, IN 99999-9999

41 RECIPIENT NAME   47 RID NO./   17 --ICN--   33 PAT NO./   49 SERVICE DATES   45 RENDERING   8 BILLED    68 DTL PAID   56 TPL           32 PAID
XXXXXXXXXX X X      36 PROC                                      PROVIDER       AMOUNT         AMOUNT       AMOUNT       9 CO-    AMOUNT
                    35 PL SERV   36 PROC      58 UNITS        FROM   THRU                                                          PAY
                              CD/25 MODIFIERS
                    99999999999  RRYYJJJBBBSSS  999999999  MMDDYY  MMDDYY  999999999X  (999.99)  (999.99)  (999.99)  (99.99)  (999.99)
                         XX     XXXXX XX XX XX XX    9999   MMDDYY  MMDDYY  999999999X   999.99    999.99
                         XX     XXXXX XX XX XX XX    9999   MMDDYY  MMDDYY  999999999X   999.99    999.99
                         XX     XXXXX XX XX XX XX    9999   MMDDYY  MMDDYY  999999999X   999.99    999.99
                         XX     XXXXX XX XX XX XX    9999   MMDDYY  MMDDYY  999999999X   999.99    999.99
                                                                                       27 NET ADJUSTED PAYMENT 999,999.99
                                                                                       42 REFUND AMOUNT APPLIED 999,999.99

15 EOBS    000   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
           001   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
           002   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999

63 ARCS    000   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
           001   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
           002   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999

64 REMARKS 000   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
           001   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
           002   9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
TOTAL NO. OF ADJUSTMENTS: 999,999           TOTAL HCFA 1500 CLAIMS PAID: 999,999.99 999,999.99 99,999.99 99.99 999,999.99
```

Figure 4 – Medical Claim Adjustments

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```
Report: CRA-0046-W              INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION        Date: MMDDYYYY
Process:                                INDIANA HEALTH COVERAGE PROGRAMS                  Time: HH:MM:SS
Location:                                      SERVICED BY EDS                            Page: 99,999

                                           PROVIDER REMITTANCE ADVICE
                                             FINANCIAL TRANSACTIONS

38 999999999 X 19
37 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                           8 CHECK/EFT NUMBER 999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX

    -------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS-------        -------------NON-CLAIM SPECIFIC REFUNDS TO PROVIDERS-------------

  57 TRANSACTION          34 PAYOUT    40 REASON   65 FIN                   42 REFUND   40 REASON  65 FIN
     NUMBER    7 --CCN--     AMOUNT       CODE        ARC       7 --CCN--      AMOUNT       CODE      ARC    41 RECIPIENT        47 RID NO.
                                                                                                              NAME
   99999999999  YYJJJBBBSSS  9,999,999.99  9999        9999      YYJJJBBBSSS    999.99     9999      9999    XXXXXXXXXX X X     999999999999
   99999999999  YYJJJBBBSSS  9,999,999.99  9999        9999      YYJJJBBBSSS    999.99     9999      9999    XXXXXXXXXX X X     999999999999
   99999999999  YYJJJBBBSSS  9,999,999.99  9999        9999      YYJJJBBBSSS    999.99     9999      9999    XXXXXXXXXX X X     999999999999
     TOTAL NON-CLAIM SPECIFIC PAYOUTS   9,999,999.99                               TOTAL NON-CLAIM SPECIFIC REFUNDS   9,999,999.99

                              -------------------ACCOUNTS RECEIVABLE-------------------

                   52 SET UP      28 ORIGINAL              40 REASON  65 FIN   29 ORIGINAL
   3 A/R NUMBER       DATE           AMOUNT     4 BALANCE     CODE      ARC     --ICN--       47 RID NO.     41 RECIPIENT
                                                                                                               NAME
   9999999999999    MMDDYY        9,999,999.99  9,999,999.99  9999      9999   RRYYJJJBBBSSS  999999999999   XXXXXXXXXX X X
   9999999999999    MMDDYY        9,999,999.99  9,999,999.99  9999      9999   RRYYJJJBBBSSS  999999999999   XXXXXXXXXX X X
   9999999999999    MMDDYY        9,999,999.99  9,999,999.99  9999      9999   RRYYJJJBBBSSS  999999999999   XXXXXXXXXX X X
   9999999999999    MMDDYY        9,999,999.99  9,999,999.99  9999      9999   RRYYJJJBBBSSS  999999999999   XXXXXXXXXX X X
   9999999999999    MMDDYY        9,999,999.99  9,999,999.99  9999      9999   RRYYJJJBBBSSS  999999999999   XXXXXXXXXX X X
     TOTAL BALANCE               9,999,999.99
```

Figure 5 – Financial Transactions

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```
Report: CRA-0147-W                        INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION          Date: MMDDYYYY
Process:                                         INDIANA HEALTH COVERAGE PROGRAMS                     Time: HH:MM:SS
Location:                                              SERVICED BY EDS                                Page: 99,999
```

```
                                        PROVIDER REMITTANCE ADVICE
                                         EOB CODE DESCRIPTIONS
```
```
[38]999999999 X [19]
[37]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          [8]CHECK/EFT NUMBER 999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX
               EOB              DESCRIPTION
        0387      THIS SERVICE IS NOT PAYABLE. THE RECIPIENT HAS NOT SATISFIED SPEND-DOWN FOR THE MONTH.
        1004      RENDERING PROVIDER NOT ENROLLED IN THE PROGRAM BILLED FOR THE DATES OF SERVICE. PLEASE VERIFY PROVIDER NUMBER AND
                  RESUBMIT.
        1010      RENDERING PROVIDER IS NOT AN ELIGIBLE MEMBER OF BILLING GROUP. PLEASE VERIFY PROVIDER NUMBER AND RESUBMIT.
        0386      THE DATE OF SERVICE ON THIS CLAIM MATCHES THE RECIPIENT'S SPEND-DOWN MET DATE FOR THE MONTH. AN 8A FORM IS REQUIRED.
                  POS PROVIDERS MUST SUBMIT THIS CLAIM ON PAPER OR THROUGH ECS.
        5001      THIS IS A DUPLICATE OF ANOTHER CLAIM.
        0391      THIS SERVICE IS NOT PAYABLE. RECIPIENT IS QUALIFIED MEDICARE BENEFICIARY (QMB) ALSO AND SPEND-DOWN HAS NOT BEEN MET.
                  ONLY REIMBURSEMEMT FOR MEDICARE COINSURANCE AND DEDUCTIBLE IS AVAILABLE. BILL MEDICARE FIRST.
        2003      RECIPIENT NOT ELIGIBLE FOR MEDICAID BENEFITS FOR DATES OF SERVICE.
        2013      RECIPIENT NOT ELIGIBLE FOR THIS LEVEL OF CARE FOR DATES OF SERVICE.
        1011      THE RECIPIENT IS ENROLLED IN HOOSIER HEALTHWISE PRIMARY CARE CASE MANAGEMENT PROGRAM. CLAIM MUST HAVE RECIPIENT'S
                  PRIMARY MEDICAL PROVIDER INFORMATION. PLEASE PROVIDE INFORMATION AND RESUBMIT.
        0342      THE CERTIFICATION CODE IS MISSING. PLESE VERIFY AND RESUBMIT.
        2504      THIS RECIPIENT IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.
        4046      THIS DATE OF SERVICE IS PRIOR TO THE PROCEDURE CODE EFFECTIVE. PLEASE VERIFY AND RESUBMIT.
        2017      THE RECIPIENT IS ENROLLED IN THE RISK BASED MANAGED CARE PORTION OF THE HOOSIER HEALTHWISE PROGRAM. THE RECIPIENT MUST
                  SEEK CARE FROM THE APPROPRIATE MANAGED CARE ORGANIZATION.
        0512      YOUR CLAIM WAS FILED PAST THE FILING TIME LIMIT WITHOUT ACCEPTABLE DOCUMENTATION.
```

Figure 6 – EOB Code Descriptions

Source for information contained in this document is the IHCP Provider Manual, Chapter 12.

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                                                                                          Indianapolis, IN 46204

First Steps
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```
Report: CRA-0147-W            INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION          Date: MMDDYYYY
Process:                           INDIANA HEALTH COVERAGE PROGRAMS                       Time: HH:MM:SS
Location:                                  SERVICED BY EDS                                Page: 99,999

                                         PROVIDER REMITTANCE ADVICE
                                           ARC CODE DESCRIPTIONS
38 999999999 X 19
37 XXXXXXXXXXXXXXXXXXXXXXXXXX                                          8 CHECK/EFT NUMBER 999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX
            ARC              DESCRIPTION
            16        CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE
                      ADVICE REMARKS CODES WHENEVER APPROPRIATE
            18        DUPLICATE CLAIM/SERVICE.
            2         COINSURANCE AMOUNT
            22        PAYMENT ADJUSTED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
            29        THE TIME LIMIT FOR FILING HAS EXPIRED.
            30        PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY
                      REQUIREMENTS.
            31        CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
            38        SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS.
            52        THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED.
            57        PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS
                      MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY.
```

Figure 7 - ARC Code Descriptions

Source for information contained in this document is the IHCP Provider Manual, Chapter 12.

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　　Indianapolis, IN 46204

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```
Report: CRA-0148-W              INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION      Date: MMDDYYYY
Process:                              INDIANA HEALTH COVERAGE PROGRAMS                 Time: HH:MM:SS
Location:                                    SERVICED BY EDS                           Page: 99,999

                                        PROVIDER REMITTANCE ADVICE
                                               SUMMARY

[38]999999999 X[19]

[37]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  [8]CHECK/EFT NUMBER 999999999
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ------------------[A]---CLAIMS DATA---------------------------
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXXXXXXXXXXXX, XX XXXXX-XXXX        CURRENT        CURRENT       YEAR-TO-DATE      YEAR-TO-DATE
                                        NUMBER         AMOUNT          NUMBER            AMOUNT
           [B] CLAIMS PAID               99,999      9,999,999.99      999,999        99,999,999.99
           [C] CLAIM ADJUSTMENTS         99,999      9,999,999.99      999,999        99,999,999.99
           [D] CLAIM INTEREST                        9,999,999.99                     99,999,999.99
               [E] TOTAL CLAIMS PAYMENTS 99,999      9,999,999.99      999,999        99,999,999.99
           [F] CLAIMS DENIED             99,999                        999,999
           [G] CLAIMS IN PROCESS         99,999


                               ------------------[H]---EARNINGS DATA-------------------------------
       [I] PAYMENTS:                                 9,999,999.99                     99,999,999.99
           [J] CLAIMS PAYMENTS                       9,999,999.99
           [K] MANAGED CARE ADMINISTRATIVE PAYMENT*  9,999,999.99
           [L] HOOSIER HEALTHWISE CAPITATION PAYMENT† 9,999,999.99
           [M] SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)   9,999,999.99
           [N] ACCOUNTS RECEIVABLE (OFFSETS):
               CLAIM SPECIFIC:
                 CURRENT CYCLE                       (9,999,999.99)                   (99,999,999.99)
                 OUTSTANDING FROM PREVIOUS CYCLES    (9,999,999.99)                   (99,999,999.99)
               NON-CLAIM SPECIFIC OFFSETS            (9,999,999.99)                   (99,999,999.99)
               PARTIAL PAYMENT(S) RECOVERIES         (9,999,999.99)                   (99,999,999.99)

           [O] NET PAYMENT**                         9,999,999.99                     99,999,999.99
```

Figure 8 – Summary (Part 1 of 2)

Source for information contained in this document is the IHCP Provider Manual, Chapter 12.

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First Steps
Reading the Remittance Advice

```
Report: CRA-0148-W              INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION          Date: MMDDYYYY
Process:                               INDIANA HEALTH COVERAGE PROGRAMS                   Time: HH:MM:SS
Location:                                       SERVICED BY EDS                          Page: 99,999

                   -------------------[H]---EARNINGS DATA-------------------------------

           [P]REFUNDS:
               [Q]CLAIM SPECIFIC ADJUSTMENT REFUNDS          (9,999,999.99)                 (99,999,999.99)
               [R]NON CLAIM SPECIFIC REFUNDS                 (9,999,999.99)                 (99,999,999.99)
           [S]OTHER FINANCIAL:
               [T]MANUAL PAYOUTS (NON-CLAIM SPECIFIC)         9,999,999.99                   99,999,999.99
               [U]VOIDS                                      (9,999,999.99)                 (99,999,999.99)
           [V] NET EARNINGS                                   9,999,999.99                  999,999,999.99

                   ---------------------[W] PAYMENTS TO LIEN HOLDERS-------------------

           LIEN HOLDER NAME
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         9,999,999.99                    9,999,999.99
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         9,999,999.99                    9,999,999.99
** NET PAYMENT AMOUNT HAS BEEN REDUCED. LIEN PAYMENTS HAVE BEEN MADE TO THE PRECEDING LIEN HOLDERS.
* MANAGED CARE ADMINISTRATIVE PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR ADMINISTRATIVE PAYMENT LISTING FOR ADDITIONAL
DETAIL.
† HOOSIER HEALTHWISE CAPITATION PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR CAPITATION PAYMENT LISTING FOR ADDITIONAL DETAIL.
```

Figure 8 – Summary (Part 2 of 2)

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February 6, 2006

First Steps Provider Quick Reference

Contact Name	How to Contact
Indiana First Steps Web Site • Obtain Provider Enrollment and Update Forms • Access the Provider Billing Manual • Access Code Sets • Access the Central Directory • View Matrix Guidelines • Search the Matrix • Update Matrix Non-Demographic Information • Obtain SPOE Locations and Contact Information • Access Provider Publications • Find a Provider Field Consultant	https://www.infirststeps.com
EDS Provider Enrollment • Submit Enrollment and Update Forms • Submit Provider Credentialing Information • Update Provider Profile Information	EDS Provider Enrollment P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750
EDS Electronic Solutions Help Desk • Obtain Technical Assistance for Web interChange • Obtain Technical Assistance with the Provider Matrix Web site • Obtain Technical Assistance Related to Transfer of Data (from SPOEs to EDS)	317-488-5160 or 1-877-877-5182
EDS Customer Assistance • Obtain Answers to Billing Questions • Obtain Answers to Questions about Cost Participation Payments	**Providers:** 317-655-3240 or 1-800-577-1278, Option 2 **Members:** 317-713-9627 or 1-800-457-4584, Option 1
Web interChange • Submit Electronic Claims • Obtain a Login and ID • Verify Physician Profile Information • Inquire About Claim Submission and Prior Authorization Requests	https://interchange.indianamedicaid.com
EDS Written Correspondence • Submit Written Inquiries	EDS Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263
Family Cost Participation Payments	First Steps P.O. Box 6097 Indianapolis, IN 46206
FSSA First Steps Web Site • Obtain Policy Information • Obtain Program Information • Obtain Training Information • Obtain Cluster SPOE and LPCC Contact Information	http://www.state.in.us/fssa/first_step/index.html

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