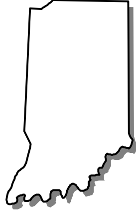
Indiana Health Coverage Programs



PROVIDER BULLETIN

BT200103 JANUARY 26, 2001

To: All Indiana Health Coverage Programs Providers

Subject: Claim Correction Form Overview

Overview

The purpose of this bulletin is to inform providers of forthcoming changes in policies and procedures for Claim Correction Forms (CCFs).

To assess whether the CCF process was an effective and efficient part of claims processing, a thorough review of the process was conducted. More than a million CCFs were generated in 1999. Some CCFs were generated because providers did not include all required information on the original claim submissions, and some CCFs were generated because of data entry errors. Of the 1,003,885 CCFs generated in 1999, approximately 50 percent were not returned. Research discovered that many providers routinely submitted a corrected claim rather than returned the CCF.

As a result of the CCF review, it was determined that changes would benefit providers and allow for expeditious claims processing. The CCF process is being discontinued for most edits; however, it remains effective for certain edits.

This bulletin presents three major changes to the CCF process that will be implemented and become effective March 19, 2001.

CCF Changes

The CCF is a formatted letter sent to a provider to indicate that a claim has been suspended because an error preventing adjudication was detected. Providers can use a CCF to update claim information and allow final adjudication of the suspended claim without resubmitting the claim. Three changes to the CCF process will be implemented and

become effective March 19, 2001. These changes are presented in this bulletin.

Elimination of certain CCFs

CCFs will be eliminated for most edits. However, CCFs for electronic claims that require attachments, and paper and electronic claims with a missing or invalid provider certification code, will remain. All other claims that previously generated CCFs will deny and not generate a CCF. Denial of claims for which a CCF was previously generated, will be denoted on the Explanation of Benefit (EOB) message on the remittance advice notice rather than on the CCF. Please refer to Table 1.1 for a list of the edits and audits that will continue to generate a CCF for either electronic claims submission (ECS) or paper claims.

Table – 1.1 Edits Generating a CCF Effective March 19, 2001

Edits and Audits	Number of CCFS Generated in 1999	Edits and Audits Currently CCF For ECS Claims	Edits and Audits Currently CCF For Paper Claims	Edits That Will Continue to Generate a CCF
0342 – Certification code missing	6,225	X	X	CCF for ECS and Paper Claims
0343 – Certification coded invalid	11,841	X	X	CCF for ECS and Paper Claims
0385 – Spenddown date same as DOS	16,593	X		CCF for ECS
0386 – Spenddown date same as DOS	12,429	X		CCF for ECS
0512 – Claims past filing limit	40,446	X		CCF for ECS
0545 – Claim past filing limit (header)	8,560	X		CCF for ECS
4019 – Procedure code requires attachment. ECS	814	X		CCF for ECS
4073 – Hysterectomy requires manual review	0	X		CCF for ECS
4075 – Sterilization requires manual review	106	X		CCF for ECS

Because elimination of CCFs for most edits would have a substantial impact on providers, the OMPP and EDS sought feedback from the provider community at the September 2000 Indiana State Medical Association (ISMA) meeting. Providers asked that the CCF process continue for the following edits:

- *0342 – Certification Code Missing*
- *0343 – Certification Code Invalid*

EDS reviewed the return rate for these edits and determined the rate to be 78 percent for edit 0342 and 54 percent for edit 0343. Therefore, these edits will continue to generate a CCF for both paper and electronic claims.

> *Note: Claims that require invoices will not generate a CCF and will need to be submitted on paper.*

Providers should consult the *Indiana Health Coverage Programs Provider Manual* for information about required attachments.

Keying Errors

Certain claims will be suspended prior to final adjudication to allow for identification and correction of keying errors made by EDS. Claims will be corrected if EDS makes a keying error. If a provider makes an error, the claim will be denied.

The following edits will suspend for review of potential keying errors:

- *0236 – "From" date of service missing*
- *0237 – "From" date of service invalid*
- *0239 – "To" date of service missing*
- *0240 – "To" date of service invalid*

Some CCFs are generated because the provider does not include all required information on the original claims. Some examples of the errors generated by these omissions are the following:

> *Note: These edits will* ***no longer*** *generate a CCF effective March 19, 2001.*

- *0203 – Recipient ID number is missing (12-digit number)*
- *0204 – Recipient ID number is not a valid format*
- *0228 – Provider signature missing*
- *0231 – Rendering provider number is missing (Required in Box 24K of the HCFA-1500)*
- *0234 – Procedure code missing*
- *0235 – Procedure code not in valid format*
- *0339 – Revenue code is missing*

- *0361 – Admitting diagnosis is missing*
- *0363 – Principal procedure code invalid*

> *Note:* Chapter 8 *of the* Indiana Health Coverage Programs Provider Manual *lists all fields required for payment. Providers must ensure all claims submitted for payment contain all required information. Providers must also ensure that the information included on the claims is valid.*

Provider Certification Statement

The Electronic Claims Certification Form has been modified and is now used as a certification statement for all providers, regardless of the media through which claims are submitted. This change will allow paper claims to be paid, rather than denied, if they are submitted without a signature *if* the certification form is on file in the Provider Fil*e.*

Provider Signature Missing

Currently, edit *0228* (Provider Signature Missing) generates a CCF for the provider's signature. CCF review determined that when edit *0228, Provider signature missing*, generates a CCF, the majority of providers returned a completed CCF for processing. This indicates that the provider did *render* the service, but omitted the required signature.

Edit 0228 is only applicable to paper claims. OMPP determined to allow paper billers to sign a certification form as electronic billers do.

Paper Billers

To eliminate generation of the CCF for edit *0228, Provider Signature Missing,* please complete the attached C*ertification Statement for Providers Submitting Claims* and return to EDS by February 15, 2001. When EDS receives the certification form, it updates each provider file. The updates allow the system to bypass edit *0228* and process the claim even if the signature is missing. If the certification form is not received by February 15, 2001, claims received on and after March 19, 2001, that do not have a physician signature will be denied. If the signature is not on the claim *and the system does not indicate that a certification form with a valid signature has been received,* the claim will be denied with edit *0228* indicating the following message:

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

Please complete the provider certification form attached to bulletin BT200103 so that future standard paper claims without a signature will not be denied for edit 228."

The attached certification form must be signed by the authorized officer, owner, or partner for the applicable IHCP provider number. The IHCP provider number and service location must be included on the lower right of the form. The form can then be matched to the correct provider file when received by EDS. One form is required for each location. The form must be returned by February 15, 2001, to the following address:

EDS Indiana*AIM*
P.O. Box 7266
Indianapolis, IN 46207-7266

Note: Faxes are not acceptable.

For more information about the claim signature requirement and provider responsibilities for claim submission, please refer to the *Indiana Health Coverage Programs Provider Manual,* the Provider Agreement, and Schedule D of the enrollment package.

Electronic Billers

Please note that the certification form previously completed by an office to enable submission of electronic claims has been revised to also include paper claims. Because all providers will have to submit some claims on paper, the form has been revised to include paper claims. **The form does not need to be signed again; however, please review the attached form and retain it with a copy of the previously signed form.** If a paper claim is submitted without a signature, the claim will be processed. The revised certification form ensures that providers understand that in the event they fail to sign the signature line of a paper claim form and the claim is approved for payment, the provider agrees that all of the stipulations, conditions, and terms of the certification statement apply. Revisions to the certification statement allow for the processing of paper claims even when a provider neglects to sign on the signature line of the paper claim form.

Benefits to the Provider

The elimination of CCFs for most edits results in the following benefits for providers:

1. Reduction in expenditures for postage.

2. Reduction in paper generated to providers.
3. Elimination of duplicate information of claim status.
4. Reduction in follow-up for the provider.

Additionally, providers who have signed the certification form attached to this bulletin will have claims processed when a signature is omitted from a paper claim. Providers continue to be responsible for all information contained on the claim form.

Additional Information

If there are questions about this bulletin, please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Certification Statement for Providers Submitting Claims

This is to certify that any and all information contained on any Medicaid or Children's Health Insurance Program (CHIP) billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (i. e. either by myself, my staff, and/or a third party acting in my behalf, such as a service bureau). I fully recognize that any billing intermediary, or service bureau that submits billings to the Family and Social Services Administration (FSSA) or its Fiscal Agent Contractor is acting as my representative and not that of FSSA or its Fiscal Agent Contractor. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for purposes of submission of Medicaid and CHIP claims.

I understand that payment and satisfaction of any claims that shall be submitted on my behalf will be from Federal and State funds, and that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable Federal and/or State law. The provider will hold harmless and indemnify FSSA from any and all claims, actions, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses, which arise out of or are alleged to have arisen out of or as a consequence of the submission of Medicaid or CHIP billings by the provider through electronic, telephonic, mechanical, and/or standard paper means of submission unless the same shall have been caused by negligent acts or omissions of FSSA.

I acknowledge that the fees and charges paid to providers for all medical services rendered or materials supplied shall be in accordance with Federal and State law and regulation with recognition of the provider's traditional right to charge for services rendered. I hereby certify that the charges submitted upon my claims shall be my usual and customary charges for my services with recognition of the provider's traditional right to charge for his services. I am aware of the restricted funding of the Indiana Health Coverage Programs, and I agree to accept as full payment for any services billed on any claims, the payment allowance determined by either the Indiana Health Coverage Programs Fiscal Agent Contractor, or the Indiana Health Coverage Programs Rate Setting Contractor.

I further certify that no supplemental charges will be billed to any Indiana Health Coverage Programs member or to the family of any member for any covered service of the Indiana Health Coverage Programs, except for copayment, patient liability payments, and any other patient payments as required by law.

I agree to keep such records as may be necessary to fully disclose the extent of services provided to individuals under the Indiana Health Coverage Programs, and to furnish such information regarding any Medicaid or CHIP payments claimed for providing such services to FSSA or its designee, upon request, for a period not less than three years from the date of service, or any such period FSSA may require. In those cases when information substitutes are allowed, I further acknowledge that I will maintain all required supporting claim documentation in my place of business and make such documentation available for review by FSSA or its Fiscal Agent Contractor. I agree to keep records independent of any paper claims, tapes, telephonic submission, or other electronic media that have been sent to its Fiscal Agent Contractor for claims payment, to document the accuracy of the service for which I have billed the Indiana Health Coverage Programs. I agree to submit such records as may be required by FSSA or the Federal Government.

I understand that FSSA or its designees are prepared to provide necessary technical assistance to assist new providers, or to correct technical problems which existing providers may experience. I realize that all communications regarding electronic, telephonic, mechanical, or standard paper submission of claims shall be between the provider in whose name the claim is submitted and FSSA or its Fiscal Agent Contractor. I further understand that this technical assistance shall consist of:

- Identification of data element requirements
- Identification of record layouts and other electronic specifications
- Identification of systematic problem areas and recommended solutions

I agree to execute a separate Certification Statement for each Indiana Health Coverage Programs (IHCP) provider number that has been issued to me. I also agree to notify either FSSA or its Fiscal Agent Contractor of any changes in my provider name or address. Further, I agree to comply with such minimum substantive and procedural requirements for claims submission as may be required by FSSA or its Fiscal Agent Contractor.

I understand that the standard paper claim form may include a signature line. I understand that all of the stipulations, conditions, and terms of the certification statement apply in the even that I fail, for any reason, to sign the paper claim and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature, in no way absolves me of the terms stated herein to which I have agreed.

I recognize that any difference of opinion concerning the amount of Indiana Health Coverage Programs payment for any claim must be adjudicated as provided in Indiana Code 4-21.5-3. Further I understand that violation of any of the provisions of this Certification Statement shall subject me to the sanctions set out in Indiana Code 12-15-22-1 and shall make the billing privilege established by this document subject to immediate revocation at FSSA's option.

THE UNDERSIGNED HAVING READ THIS CERTIFICATION STATEMENT AND UNDERSTANDING IT IN ITS ENTIRETY DOES HEREBY AGREE TO ALL OF THE STIPULATIONS, CONDITIONS AND TERMS STATED HEREIN.

Provider Name　　　　　　Title

Provider Signature　　Date　　　　IHCP Provider Number/Service Location