INDIANA HEALTH COVERAGE PROGRAMS

Claim Submission and Processing

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of July 1, 2016 Published: December 15, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of July 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: May 23, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of July 1, 2017 Published: January 23, 2018	Scheduled update:	FSSA and DXC
3.0	Policies and procedures as of April 1, 2018 Published: September 6, 2018	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of July 1, 2019 Published: December 10, 2019	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of July 1, 2020 Published: March 23, 2021	Scheduled update: • Reorganized and edited text as needed for clarity • Updated Portal screen graphics as needed • Added note about DXC name change to Gainwell • Added exceptions for NEMT in *Section 1: Introduction to IHCP Claim Submission and Processing* • Added font options in the *Paper Claim Submission Guidelines* section • Updated the *Provider Healthcare Portal Claims* section • Updated the *Search Payment History* section • Updated the note about paper attachments for Portal claims in the *Mailing Paper Attachments for Electronic Claims* section	FSSA and Gainwell

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Version	Date	Reason for Revisions	Completed By
		- Updated the *Claim Notes* section and subsections: – Corrected to reflect that the Portal accepts a claim note at the detail level for professional claims – Added a note in the *Claim Notes Accepted as Documentation* subsection – Added the *Adjustments Related to Overpayment* subsection – Updated the *Retroactive Eligibility* subsection - Added note to the *ICD Codes* section - Updated the reference for outpatient reimbursement information (now in the Outpatient Fee Schedule) in the *Revenue Codes* section - Updated *Table 4 – UB-04 Claim Form Fields* - Updated the *Portal Institutional Claim Submission Process* subsections - Added notes about changes to provider types/specialties in to *Table 5 – Types of Services Billed on Professional Claims* - Updated *Table 6 – CMS-1500, Version 02/12, Claim Form Fields* - Updated the *Portal Professional Claim Submission Process* subsections - Updated the *Portal Dental Claim Submission Process* subsections - Updated the *Documenting Denied or Zero-Paid Claims* section, including *Table 9 – Valid Adjustment Reason Code* - Added Package B to *Section 6: Special Billing Instructions for Specific IHCP Benefit Plans* - Updated the *Emergency Services Only (Package E) Billing* section - Added the *Emergency Services Only Coverage with Pregnancy Coverage (Package B) Billing* section - Updated *Table 17 – Claims Returned to Provider* - Updated the *Medicare-Denied Details on Crossover Claims* section	

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Section 1: Introduction to IHCP Claim Submission and Processing

> *Note:* *The information in this module applies to Indiana Health Coverage Programs (IHCP) claim submission and processing for services delivered through the **fee-for-service (FFS)** delivery system, with the following exceptions:*
>
> - *Pharmacy services reimbursed through the FFS pharmacy benefit manager, OptumRx (see the [Pharmacy Services](#) module)*
> - *Nonemergency medical transportation (NEMT) services reimbursed though the FFS transportation broker, Southeastrans (see the [Transportation Services](#) module)*
>
> *For services provided through the managed care delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual.*
>
> *Contact information for OptumRx, Southeastrans, and each MCE is included in the [IHCP Quick Reference Guide](#) at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see [IHCP Banner Pages and Bulletins](#) at in.gov/medicaid/providers.*

The Indiana Health Coverage Programs (IHCP) contracts with DXC Technology to serve as its fiscal agent. As such, DXC performs claim-processing functions for all IHCP fee-for-service (FFS) billing, except for pharmacy services and brokered nonemergency medical transportation (NEMT).

> *Note:* *On October 1, 2020, the name of the IHCP fiscal agent changed from DXC Technology to Gainwell Technologies.*

This module provides information about IHCP claim completion and processing for services billed to DXC, including the following topics:

- Claim completion guidelines – Provides general information about submitting institutional, professional, and dental claims to the IHCP, including detailed, field-by-field instructions for completing the following paper claim forms:
  - *UB-04* claim form
  - *CMS-1500* claim form
  - *ADA 2012* claim form

> *Note:* *Providers are encouraged to submit claims electronically rather than use paper claim forms. See the [Electronic Claims](#) section for details.*

- Claim processing overview – Provides step-by-step procedures of how paper and electronic claims are processed through the IHCP Core Medicaid Management Information System (*Core*MMIS).

- Crossover claim processing procedures – Outlines what happens when a claim automatically crosses over from a Medicare carrier and what to do when the claim does not automatically cross over.

- Suspended claim resolution – Provides an overview of why and how a claim suspends, resolution procedures, and processing timeliness guidelines.

- Claim filing limits – Summarizes provider responsibilities concerning filing limits, eligible claims, and filing limit waiver documentation.

For claim information specific to a particular provider service, see the appropriate provider reference module. For information about avenues of resolution when a provider disagrees with a claim denial or payment amount, see the *Claim Administrative Review and Appeals* module. For information about claim adjustments, see the *Claim Adjustments* module.

Fee-for-Service Billing for Carved-Out Services

Claims for services provided under the managed care delivery system are submitted to and processed by the managed care entity (MCE) in which the HIP, Hoosier Care Connect, or Hoosier Healthwise member is enrolled (or vendors contracted by that entity). However, certain services are "carved out" of the managed care programs.

Carved-out services for managed care members are the financial responsibility of the State. These carved-out services are billed as FFS claims and are submitted to and processed, directly or indirectly, by DXC or, for pharmacy claims, OptumRx (the FFS pharmacy benefit manager).

For a list of services carved out of the managed care programs, see the *Member Eligibility and Benefit Coverage* module.

Paper Claim Forms

The IHCP accepts the following claim forms:

- *UB-04* (*CMS-1450*) institutional claim form

- *CMS-1500 (02/12)* professional claim form

- *ADA 2012* dental claim form

- *Indiana Medicaid Drug Claim Form* (National Council for Prescription Drug Programs [NCPDP] Drug Claim Form)

- Indiana Medicaid Compounded Prescription Claim Form

> Note: *Providers can download the IHCP Drug Claim Form, the IHCP Compound Prescription Claim Form, and related instructions from the PA Criteria and Administrative Forms quick link on the OptumRx Indiana Medicaid website, accessible from the Pharmacy Services page at in.gov/medicaid/providers. See the Pharmacy Services module for information about pharmacy-related claim submission and processing.*

Ordering Claim Forms

Providers can order *UB-04*, *CMS-1500*, and *ADA 2012* claim forms from a standard form supply company.

Professional (*CMS-1500*) and institutional (*UB-04*) paper claims submitted to the IHCP must be on the official **red** claim forms developed by the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC). The IHCP will not accept black-and-white copies of these forms. This change does not apply to dental claims submitted on the approved American Dental Association (ADA) claim form.

Claims that are not submitted on the correct form will be returned to providers without being processed. Returned claims must be resubmitted on the correct claim form. Timely filing requirements apply to resubmitted claims.

Paper Claim Submission Guidelines

To assist providers using paper claims, the IHCP has identified specific billing errors that may cause processing delays or increase paper claim processing errors. To avoid these errors, providers should adhere to the following paper claim billing processes:

- Submit paper claims on the standard, approved claim form for the type of service being billed. For institutional and professional claims, the official red claim form (not a black-and-white copy) must be used.

- Use Arial, Helvetica, Times New Roman, or Courier font type with 10–14-point font size.

- Avoid using handwritten information on the claim forms unless directed to do so.

- Use only blue or black ink.

- Do not add highlighting or any other color marks.

- Do not use liquid paper correction fluid or correction tape.

- Ensure information is documented in the appropriate boxes on the form and is aligned correctly in those boxes.

- Add data within the boxes on the form. Data outside the approved fields can cause errors and delay processing.

- Do not enter commas or dashes.

- Do not write or type any information outside the borderline of the form (other than the appropriate address, placed at the top of the *CMS-1500* claim form).

- Do not put stray marks or Xs on the claim form.

- Paper claims that require attachments must include the attachments with the claim form.

- Do not add stamps or stickers.

- Submit attachments on standard 8½-by-11-inch paper.

- Do not use paper clips or staples on claim forms or attachments.

Claim Submission Addresses

Mail all fee-for-service claims, including those that have passed the filing limit, to DXC. For managed care members, providers should send claims to the appropriate MCE, unless otherwise indicated.

See the *IHCP Quick Reference Guide* at in.gov/medicaid/providers for DXC and MCE mailing addresses.

Provider Signatures

Provider signatures are not required on paper claim forms. However, all providers must have a signature on file with the IHCP for the claim to be processed.

Electronic Claims

Providers can bill claims electronically instead of using paper claim forms. Electronic claims must be submitted in the 837 American National Standards Institute (ANSI) formats or through the direct data entry (DDE)-compliant web portal called the IHCP Provider Healthcare Portal (Portal).

> *Note: Pharmacies submit drug claims at the point of sale (POS). See the* [*Pharmacy Services*](#) *module for information about pharmacy-related claim submission and processing. The IHCP Companion Guide for electronic pharmacy claim transactions, NCPDP Version D.0 Transaction Payer Sheet, can be accessed from the* [*OptumRx Indiana Medicaid website*](#).

837 Electronic Transactions

The IHCP accepts the following electronic transactions:

- 837I (Institutional)
- 837P (Professional)
- 837D (Dental)

The *Health Insurance Portability and Accountability Act* (HIPAA) specifically names several electronic standards that must be followed when certain healthcare information is exchanged. These standards are published as *National Electronic Data Interchange Transaction Set Implementation Guides,* commonly called implementation guides (IGs). An addendum to most IGs has been published and must be used to properly implement each transaction. The IGs are available for purchase and download through the [Washington Publishing Company website](#) at wpc-edi.com.

The IHCP has developed technical companion guides to assist application developers during the implementation process. Information contained in the *IHCP Companion Guides* is intended only to supplement the adopted IGs and provide guidance and clarification as it applies to the IHCP. The *IHCP Companion Guides* are never intended to modify, contradict, or reinterpret the rules established by the IGs. The *IHCP Companion Guides* are located on the [*IHCP Companion Guides*](#) page at in.gov/medicaid/providers.

For more information about HIPAA compliance for electronic transactions, including claim submission using the 837 format, see the [*Electronic Data Interchange*](#) module.

> *Note: The IHCP accepts as many as 5,000 Claim (CLM) segments per Transaction Set Header segment (ST) – Transaction Set Trailer segment (SE).*
>
> *Some data elements that providers submit may not be used in processing the 837 transactions; however, those data elements may be returned in other transactions, such as the 277 Claim Status Request and Response or the 835 Remittance Advice transactions. These data elements are necessary for processing, and failure to append them may result in claim suspension or claim denial.*

Provider Healthcare Portal Claims

The Portal allows registered users to submit individual FFS, nonpharmacy claims to the IHCP through a secure, web-based application. Information about registering a Portal account and assigning permissions can be found in the *Provider Healthcare Portal* module.

The Portal accepts all FFS **institutional**, **professional**, and **dental** claims, including:

- Inpatient
- Outpatient
- Home health
- Hospice
- Long-term care
- Medical
- Dental
- Medicare and Medicare Replacement Plan crossover claims

A claim submitted through the Portal is assigned a Claim ID, which can be used for tracking purposes, and is available for viewing through claim inquiry.

To access claim-related options on the Portal, log in to the appropriate account and then select the **Claims** tab from the menu bar to go to the *Claims* page or hover your cursor over the **Claims** tab to activate the drop-down menu (see Figure 1). Options include:

- Search Claims
- Submit Claim (Dental, Institutional, or Professional)
- Search Payment History

Figure 1 – Claims Page Menu Options

Search Claims

The *Search Claims* page enables users to locate a previously submitted claim based on various search criteria, as follows:

1. From the Portal menu bar, select **Claims > Search Claims**.

2. In the *Search Claims* panel, enter at least one field to conduct a search. For more targeted results, enter a combination of fields. Search for a claim using:
   – Claim information (Claim ID)
   – Member information (Member ID, birth date, first or last name)
   – Service information (claim type, service dates, paid date, claim status)

   Paid Date or Service From and To fields are required if no claim information is entered on the request.

Figure 2 – Search Claims

3. Click **Search** to see results. The search results display basic information for claims matching the search criteria, including the Claim ID, claim type, claim status, service date, Member ID, Medicaid paid amount, and paid date.

Figure 3 – Claim Search Results

> *Note: If an adjustment has been submitted for a claim, the adjustment will be listed in the search results if you search by Member ID and date of service.*

4. Click the desired Claim ID link to view details about a particular claim (Figure 4).

Figure 4 – Claim Detail Information

Note: Additional information about the claim and claim processing may be displayed by clicking the plus sign [+] to expand each panel.

5. If any documents were submitted as attachments to the claim, you can expand the *Attachments* panel (Figure 5) and click the **View** link to view each document.

Figure 5 – Attachments Panel of Claim Detail

Attachments				▬
Click the **View** link to view the document. **The View link is available for attachments that have been received.**				
#	Transmission Method	Control #	Attachment Type	Action
1	FT- File Transfer	12312312312333	06-Initial Assessment	View
2	BM - By Mail	31231231231233	PY-Physicians Report	View

Submit Claim

For step-by-step instructions for submitting institutional, professional, and dental claims through the Portal, see Sections 2, 3, and 4 of this module. The following *general* instructions apply for all claim types.

Completing the Claim

Claim submissions must be completed in a single session, so make sure to have all the necessary information before starting the submission. There is not an option to save and complete the claim at a later time.

> Note: If you need to go back to a previous step during the claim-submission process, do not
> use the breadcrumbs at the top of the page or the Back button on your browser;
> instead, use the **Back to Step x** buttons at the bottom of the page to move between
> steps; otherwise, your data may be lost.
>
> [Back to Step 1]   [Back to Step 2]

Throughout the submission process for all claim types, providers must complete required fields (marked with an asterisk [*]) before they can continue to the next step in the Portal process. However, the asterisk does not necessarily indicate all fields that are required for a claim to be reimbursed. Based on factors such as the procedure code billed, the provider specialty submitting the claim, and so forth, some fields without an asterisk may be denied with an appropriate EOB if they were left blank during the Portal claim-submission process.

What Happens after a Claim Is Submitted?

The following steps occur after you submit a claim through the Portal:

1. The Portal displays the Claim ID and current claim status. Use the Claim ID to look up the status of the claim or to reference the claim any time during an inquiry.

Figure 6 – Claim ID and Status

Submit Institutional Claim: Confirmation	?
Institutional Claim Receipt	

Your Institutional Claim was successfully submitted. The claim status is PendingInProcess.
The Claim ID is 0000000000000.

Click **Print Preview** to view the claim details as they have been saved on the payer's system.
Click **Copy** to copy member or claim data.
Click **New** to submit a new claim.

[Print Preview]   [Copy]   [New]

2. The data from the claim entered in the Portal is transferred to *Core*MMIS, the IHCP claim-processing system.

3. The claim is reviewed for accuracy, completeness, and validity before it is approved, denied, or suspended/pended for additional review. (See the *Provider Healthcare Portal Claim Processing* section.)

4. The status of the claim is updated in the Portal. The status will show as "Finalized Denied," "Finalized Payment," or "Pending in Process."

5. Additional claim information, such as Remittance Advice, is updated in the Portal as it becomes available.

Search Payment History

The *Search Payment History* page is used to view electronic funds transfer (EFT) and to check payment records for claims and zero-pay payments. This page is also where users can view the Remittance Advice (RA) for claims. For details, see the *Financial Transactions and Remittance Advice* module.

Mailing Paper Attachments for Electronic Claims

Providers must follow certain procedures when submitting paper attachments associated with an electronic claim. For 837 electronic claim transactions (submitted through File Exchange), providers **must** submit all attachments by mail, following the process described in this section.

> *Note: When submitting claims via the Portal, providers are strongly encouraged to upload attachments electronically, as described in the Attachments section in the institutional, professional, and dental claim-submission instructions in Sections 2, 3, and 4 of this module. However, in cases where uploading to Portal is not possible, such as when the file size is too large, the IHCP also accepts attachments submitted by mail for Portal claims. Providers should indicate in the Portal claim that attachments are being submitted by mail, and then follow the instructions in this section to prepare and send the attachments.*

The following steps describe how to submit paper attachments to electronic claims by mail:

1. Assign a unique attachment control number (ACN) to each paper attachment to be submitted, and write the ACN on each page of each attachment.
   – An ACN can be up to 30 characters in length, and can be numbers, letters, or a combination of letters and numbers.
   – After an ACN has been used, it cannot be used again, even if the same claim is resubmitted at a later date.
   – Documents cannot be shared between claims.
   – The ACN must be written on the top of the document. If an attachment has more than one page, the ACN must be written on each page of the document.
   – Write in only blue or black ink on the attachments.

6. Complete an IHCP *Claims Attachment Cover Sheet* for each set of attachments associated with a specific claim. The *Claims Attachment Cover Sheet* is available on the *Forms* page at in.gov/medicaid/providers. Include the following information on the *Claims Attachment Cover Sheet:*
   – Billing provider's name, service location address, and ZIP Code+4
   – Billing provider's National Provider Identifier (NPI) or IHCP Provider ID
      ➢ Only atypical providers may use the IHCP Provider ID.
      ➢ See the *Provider Enrollment* module for more information about NPIs and Provider IDs.
   – Dates of service on the claim
   – IHCP Member ID (also known as RID)
   – ACN for each attachment associated with the claim (The provider may submit a maximum of 20 ACNs with each cover sheet.)
   – Number of pages associated with each attachment (not including the cover page)

7. Indicate on the 837 transaction or the Portal claim, as follows, that additional documentation will be submitted:

   – Enter an attachment report transmission code. This required code indicates whether an electronic claim has documentation to support the billed services. This code defines the timing and transmission method or format of reports and how they are sent. The IHCP accepts paper attachments only by mail. This attachment transmission code is BM (by mail).

   ➢ 837 transaction: Enter **BM** in loop 2300, segment PWK02, data element 756.

   ➢ Portal: Select **BM – By Mail** in the Transmission Method field of the *Attachments* panel.

   – Enter the unique ACN for the attachment. The ACN entered must match the ACN on the *Claims Attachment Cover Sheet* and on each page of the attachment sent by mail.

   ➢ 837 transaction: Enter the ACN in loop 2300, segment PWK, data element 67.

   ➢ Portal: Enter the ACN in the Control # field of the *Attachments* panel.

   – Enter an attachment report type code. This code indicates the type of attachment the provider is sending to the IHCP to support the electronic claim. The code indicates the title or contents of a document, report, or supporting item. For a complete listing of attachment report type codes, see the appropriate 837 claim transaction IG, or see Table 1 in this document.

   ➢ 837 transaction: Enter the attachment report type code in loop 2300, segment PWK01, data element 755.

   ➢ Portal: Select the appropriate code from the Attachment Type field of the *Attachments* panel.

8. Mail the attachments and cover sheet to the following address:

   DXC Claim Attachments
   P.O. Box 7259
   Indianapolis, IN 46207

> *Note: Attachments must be received within 45 calendar days of the date the electronic claim is received, or the claim will be denied.*

The Claims Unit reviews each *Claims Attachment Cover Sheet* for completeness and accuracy of the number of ACNs to the number of attachments. If errors are found, the cover sheet and attachments are returned to the provider for correction and resubmission. If the attachments are not received within 45 days, the claim is automatically denied. If the provider has submitted the attachments, but one specific attachment needed for processing is missing from the batch, the claim or detail line is denied.

Providers receive a return to provider (RTP) letter when the *Claims Attachment Cover Sheet* is not included with the attachment, when required information (such as Member ID) is missing or invalid, or when the provider's office location cannot be determined using the NPI, ZIP Code+4, and taxonomy code. When a provider receives an RTP letter, the necessary corrections must be made and the attachment resubmitted with the cover sheet. The documents must be received at DXC within 45 days of the claim submission date.

Table 1 – Report Type Codes

Report Type Code	Type of Attachment	Dental/ 837D	Professional/ 837P	Institutional/ 837I
03	Report Justifying Treatment Beyond Utilization Guidelines		X	X
04	Drugs Administered		X	X
05	Treatment Diagnosis		X	X
06	Initial Assessment		X	X
07	Functional Goals		X	X
08	Plan of Treatment		X	X

Report Type Code	Type of Attachment	Dental/ 837D	Professional/ 837P	Institutional/ 837I
09	Progress Report		X	X
10	Continued Treatment		X	X
11	Chemical Analysis		X	X
13	Certified Test Report		X	X
15	Justification for Admission		X	X
21	Recovery Plan		X	X
A3	Allergies/Sensitivities Document		X	X
A4	Autopsy Report		X	X
AM	Ambulance Certification		X	X
AS	Admission Summary		X	X
B2	Prescription		X	X
B3	Physician Order		X	X
B4	Referral Order	X	X	X
BR	Benchmark Testing Results		X	X
BS	Baseline		X	X
BT	Blanket Test Results		X	X
CB	Chiropractic Justification		X	X
CK	Consent Form(s)		X	X
CT	Certification		X	X
D2	Drug Profile Document		X	X
DA	Dental Models	X	X	X
DB	Durable Medical Equipment Prescription		X	X
DG	Diagnostic Report	X	X	X
DJ	Discharge Monitoring Report		X	X
DS	Discharge Summary		X	X
EB	Explanation of Benefits	X	X	X
HC	Health Certificate		X	X
HR	Health Clinic Records		X	X
I5	Immunization Record		X	X
IR	State School Immunization Records		X	X
LA	Laboratory Results		X	X
M1	Medical Record Attachment		X	X
MT	Models		X	X
NN	Nursing Notes		X	X
OB	Operative Notes		X	X
OC	Oxygen Content Averaging Report		X	X
OD	Orders and Treatment Document		X	X
OE	Objective Physical Examination Document		X	X

Report Type Code	Type of Attachment	Dental/ 837D	Professional/ 837P	Institutional/ 837I
OX	Oxygen Therapy Certification		X	X
OZ	Support Data for Claim	X	X	X
P4	Pathology Report		X	X
P5	Patient Medical History Document		X	X
P6	Periodontal Charts	X		
PE	Parental or Enteral Certification		X	X
PN	Physical Therapy Notes		X	X
PO	Prosthetics or Orthotic Certifications		X	X
PQ	Paramedical Results		X	X
PY	Physician's Report		X	X
PZ	Physical Therapy Certification		X	X
RB	Radiology Films	X	X	X
RR	Radiology Reports	X	X	X
RT	Report of Tests and Analysis Report		X	X
RX	Renewable Oxygen Content Averaging Report		X	X
SG	Symptoms Document		X	X
V5	Death Certificate		X	X
XP	Photographs		X	X

Note: The values in this table are taken from the X12 837 Implementation Guides (IGs). The IGs are the official source of this information, and so providers should always refer to the most current version of the IGs for accepted values. The IGs are available for purchase and download through the Washington Publishing Company website at wpc-edi.com.

Claim Notes

The IHCP accepts claim note information in electronic claim transactions and retrieves the information for review during processing. This feature reduces the number of attachments that must be sent with claims. Also, in some instances, use of the claim note may assist with the adjudication of claims. For example, when postoperative care is performed within 1 day of surgery, providers can submit supporting information in the claim note segment rather than sending an attachment.

When a provider submits claims electronically via an 837 transaction or the Portal, the number of claim notes allowed varies by claim type as follows:

- Dental claims submitted via the Portal or 837D transaction allow five claim notes at the header level.

- Institutional claims submitted via the Portal or 837I transaction allow 10 claim notes at the header level.

- Professional claims submitted via the Portal or 837P transaction allow one claim note at the header level and one claim note at the detail level.

Note reference codes identify the functional area or purpose for which the note applies. For example: ADD – *Additional Information.*

For details about entering claim notes online, see the *Claim Note Information* sections in the institutional, professional, and dental claim instructions in this module. For details about entering claim notes on the 837 electronic transactions, see the 837 IGs and the *IHCP Companion Guides*.

> *Note: The IHCP does not accept all types of claim notes as documentation. Providers should submit claim notes to IHCP **only if** the notes relate to any of the situations described in this section.*

Claim Notes Accepted as Documentation

The following sections describe types of claim notes that the IHCP accepts as documentation.

> *Note: Adding a claim note will force the claim to Pending in Process status, which may delay the processing of the claim. If a claim note is not needed, do not add one.*

Third-Party Payer Fails to Respond (90-Day Provision)

When a third-party insurance carrier fails to respond within 90 calendar days of the billing date, the provider can submit the claim to the IHCP for payment consideration. However, to substantiate attempts to bill the third party, the following must be documented in the claim note:

- Dates of the filing attempts
- The phrase: "**No response after 90 days**"
- IHCP Member ID
- IHCP Provider ID
- Name of primary insurance carrier billed

If submitting unpaid bills or statements, providers should include the third-party insurance carrier's name. Likewise, if providing a written notification with billing dates, providers need to include the name of the third-party insurance company.

Consultations Billed 15 Days before or after Another Consultation

In the claim note, the provider can indicate the medical reason for a second opinion during the 15 days before or after a billed consultation.

Joint Injections – Four per Month

In the claim note, the provider can document that injections were performed on different joints, and indicate the sites of the injections.

Surgery Billed with Related Postoperative or Preoperative Care

Providers should use the claim note to document when surgery is payable at a reduced amount because related postoperative or preoperative care paid on same date of service, or to document separate billing for postoperative care within 90 days of surgery or preoperative care on the day of surgery.

In the claim note, the IHCP accepts the following:

- Information that documents the medical reason and unusual circumstances for the separate evaluation and management (E/M) visit

- Information that supports that the medical visit occurred due to a complication, such as cardiovascular complications, comatose conditions, elevated temperature for 2 or more consecutive days, medical complications other than nausea and vomiting due to anesthesia, postoperative wound infection requiring specialized treatment, or renal failure

Adjustments Related to Overpayment

Overpayment adjustment requests are not subject to timely filing limits. When submitting an overpayment adjustment after a claim is beyond the standard filing limit, providers must include an attachment or a claim note indicating "**adjustment due to overpayment**" or "**overpayment adjustment**," so that the claim does not automatically deny.

Pacemaker Analysis – Two within 6 Months

The provider should use the claim note to document the medical reason for a second pacemaker analysis within the 6-month time frame, such as a dysfunctional pacemaker.

Assistant Surgeon Not Payable When Cosurgeon Paid

In the claim note, the IHCP accepts information that documents the medical reason for the assistant surgeon, such as the situational problem requiring assistance.

Excessive Nursing Facility Visits or More Than One per 27 Days

In the claim note, the IHCP accepts documentation supporting the need for more than one nursing facility visit per 27 days, such as the treatment of emergent, urgent, or acute conditions or symptoms with the new diagnosis code.

Retroactive Eligibility

Use claim notes when billing a claim that is past the filing limit (180 days after date of service) and the member was awarded retroactive eligibility. In the case of retroactive member eligibility, claims must be submitted within 180 days of the eligibility determination date. The claim note must include the following text: "**Retroactive eligibility. Please waive timely filing**."

If submitting the claim via the Portal, select Additional Information from the Note Reference Code drop-down menu and then write the note in the Note Text field.

.Mental Health Procedure Codes with Midlevel-Practitioner Modifier for Dually Eligible Members When the Provider Is Not Approved to Bill Medicare

When billing for services provided to members who are dually eligible for Medicare and Medicaid, mental health providers that submit claims using procedure codes with a midlevel practitioner modifier (such as HE or HO) may use claim notes to indicate that the provider that performed the service is not approved to bill services to Medicare. The claim note must include the following text: "**Provider not approved to bill services to Medicare.**" The use of claim notes allows the claim to suspend for review of the claim note and be adjudicated appropriately.

Essure Sterilization

For all claims related to hysteroscopic sterilization with an Essure implant device, providers must write "**Essure sterilization**" in the claim note (for electronic claims) or on the accompanying invoice.

Partial Sterilization

Claims for sterilization and related procedures require a *Consent for Sterilization* form. When billing for a *partial* sterilization or a service related to a partial sterilization, providers may indicate "**partial sterilization**" in the claim note. When the claim suspends for review of the *Consent for Sterilization* form, this claim note serves as documentation that the *Consent for Sterilization* is not required.

Community Health Worker Name

IHCP-enrolled providers submitting claims for community health worker (CHW) services must include the name of the CHW who performed the services in the claim notes.

General Billing and Coding Information

This section provides general information and definitions for IHCP claim completion. For information specific to a particular type of claim or 837 transaction, see the sections that follow.

National Provider Identifier and One-to-One Match

The National Provider Identifier (NPI) is the standard, unique identifier for healthcare providers and is assigned by the National Plan and Provider Enumeration System (NPPES).

All healthcare providers **must** bill using their NPI on all claims. Only atypical, nonhealthcare providers can bill using their IHCP Provider ID.

The NPI must crosswalk to one IHCP Provider ID or the claim will be denied. Three data elements are used for the standard NPI crosswalk, to establish a one-to-one match:

- Billing NPI
- Billing taxonomy code
- Billing provider **service location** ZIP Code+4 on file in *Core*MMIS

> *Note: Providers can use the Portal to view and update their information on file with the IHCP. See the [Provider Enrollment](#) module for information on how to view and update information through the Portal as well as how to obtain an NPI.*

Diagnosis and Procedure Coding Systems

The IHCP uses the International Classification of Diseases (ICD) and Healthcare Common Procedure Coding System (HCPCS) Level I and II coding systems. Each coding system is described as follows:

- ICD codes, developed by the World Health Organization (WHO), are divided into two systems:
  - Clinical Modification (CM) for diagnostic coding
  - Procedure Coding System (PCS) for inpatient hospital procedure coding
- HCPCS Level I codes are Current Procedural Terminology (CPT[®][1]) numeric codes and modifiers created by the American Medical Association (AMA).
- HCPCS Level II codes are A through V alphanumeric codes and modifiers created by the Centers for Medicare & Medicaid Services (CMS). These codes identify products, supplies, materials, and services that are not included in the CPT code book. The Current Dental Terminology (CDT[®][2]) code

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[2] *CDT copyright 2020 American Dental Association. All rights reserved.*

set, produced and maintained by the American Dental Association (ADA), is included in Level II of the HCPCS.

Except where otherwise noted, the IHCP uses coding practices created and published by these entities. Coding exceptions and clarifications are noted throughout the remainder of this document. Additional exceptions related to the Medicare resource-based relative value scale (RBRVS) reimbursement system are noted in the *Medical Practitioner Reimbursement* module.

Providers should always monitor all IHCP bulletins and banner page articles for future coding information and clarification of billing practices.

ICD Codes

The IHCP adheres to the coding guidelines published in the *AHA Coding Clinic for ICD*, a publication of the American Hospital Association, Central Office. The following ICD coding clarifications may assist providers in completing their claim submissions:

- Use the highest level of specificity when billing diagnostic and procedure codes.

  > *Note: Claims for dates of service on or after July 1, 2020, will deny if any ICD-10-CM diagnosis codes do not contain the highest level of specificity. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.*

- Use the codes labeled *other specified or not elsewhere classified (NEC)*, *unspecified*, or *not otherwise specified (NOS)* only when the diagnostic statement or a thorough review of the medical record does not provide adequate information to permit assignment of a more specific code.

- Use the code assignment for *other* or *NEC* when the information at hand specifies a condition but no separate code for that condition is provided.

- Use *unspecified* or *NOS* when the information at hand does not permit either a more specific or other code assignment.

Primary (or principal) diagnosis codes are required on *all* IHCP professional and institutional claim submissions. This requirement applies to providers that were previously exempt from submitting diagnosis codes specific to transportation, waiver, and durable medical equipment (DME) services. Transportation and waiver providers should bill ICD-10 diagnosis code R69 – *Illness, unspecified* as the primary diagnosis code for claim submissions when the actual diagnosis is not known. DME providers must obtain the primary diagnosis code from the physician who ordered the DME supplies or equipment. Claims submitted to the IHCP without a valid diagnosis code will be denied. (Diagnosis codes are optional on dental claim submissions.)

Providers must use ICD-10 for all ICD-CM and ICD-PCS codes on claims with dates of service on or after October 1, 2015.

Add-On Codes

Add-on codes are procedure codes that indicate additional work associated with another primary procedure. Add-on codes are always performed in conjunction with another primary service, with one exception: CPT code 99292 – *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*.

CPT add-on code 99292 may be paid to a physician who does not report CPT code 99291 if another physician of the *same* specialty in his or her group practice is paid for CPT code 99291 on the same date of service. For the code to be processed correctly, the provider must follow the administrative review process for the appropriate adjudication review.

Procedure Codes That Require Claim Attachments

Some HCPCS codes require providers to submit attachments with the claims. If providers submit claims for these codes and do not submit attachments, the IHCP denies the claims. These codes are listed in *Procedure Codes That Require Attachments*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

National Correct Coding Initiative

The IHCP applies National Correct Coding Initiative (NCCI) editing to medical services billed on professional and outpatient institutional claims. NCCI editing occurs on claims billed with the same date of service, same member, and same billing provider NPI. For more information on NCCI, see the *National Correct Coding Initiative* module.

Units of Service

Providers cannot bill partial units of service. Providers must round partial units of service to the nearest whole unit when calculating reimbursement. For example, if a unit of service equals 15 minutes*, a minimum of 8 minutes* must be provided to bill for one unit.

> *Note:* *For certain services, such as smoking cessation services, providers must accumulate time equivalent to whole units before billing, rather than rounding to the nearest whole unit.*

Modifiers

Professional and institutional claims on the Portal, 837P and 837I electronic transactions, and *CMS-1500* and *UB-04* claim forms accept up to four modifiers per procedure code. Currently, no modifiers are approved for use with the CDT code set on the dental claim form.

Correct use of modifiers is essential to accurate billing and reimbursement for services provided. When trying to determine whether or not a modifier is appropriate, providers should ask the following questions:

- Will a modifier provide additional information about the services provided?
- Was the same service performed more than once on the same date?
- Will the modifier give more information about the anatomic site of the procedure?

If any of these circumstances apply, it may be appropriate to add a modifier to the procedure code. It is also important that the medical-records documentation supports the use of the modifier.

For a list of modifiers used on the professional claim (*CMS-1500* claim form or electronic equivalent), see *Procedure Code Modifiers for Professional Claims*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Modifiers are categorized according to type. Table 2 lists the definition for each modifier type.

Table 2 – Types of Modifiers

Type	Definition
Informational	Used to denote additional information that may or may not affect claim processing.
Pricing	Used to read a fee segment. A rate is linked to the procedure code modifier combination.
Processing	Used to modify a fee segment by a percent or by a dollar amount.
Review	Causes a claim to suspend for review. Procedure code linkage is not required for these modifiers.
Anesthesia	Used to modify anesthesia service fee segments by a percent.
Physical Status	Used to modify the anesthesia units submitted on the claim form.

> *Note: Providers should always include any modifier that is applicable according to correct coding criteria.*

The following are some of the many resources available for obtaining additional information:

- The CMS provides carriers with guidance and instructions on the correct coding of claims and using modifiers through manuals, transmittals, and the CMS website at cms.hhs.gov.

- The *National Correct Coding Initiative (NCCI) Edits* page at cms.gov provides updates each quarter for correct modifier usage for each CPT code.

- The American Medical Association (AMA) *CPT Assistant Newsletter* and *Coding with Modifiers* reference manual are other valuable resources for correct modifier usage.

Providers must ensure that the use of the modifier is justifiable based on generally accepted coding guidance (for example, from the AMA or the CMS) that defines the appropriate use of modifiers.

Modifiers may be appended to HCPCS/CPT codes only when clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass NCCI editing. *The National Correct Coding Initiative in Medicaid* page at medicaid.gov provides specific guidance on proper use of modifiers. The use of modifiers affects the accuracy of claim billing, reimbursement, and NCCI editing. In addition, modifiers provide clarification of certain procedures and special circumstances.

For information about how certain modifiers, including midlevel practitioner modifiers, affect claim payment, see the *Medical Practitioner Reimbursement* module. A summary of key modifiers used in billing and general guidance for usage follows.

Modifier 50

Bilateral procedures are performed during the same operative session on both sides of the body by the same physician. The units billed would be entered as "1," because one procedure was performed bilaterally. See the *Surgical Services* module for additional information.

Modifier 51

When multiple procedures or services are performed on the same day or during the same operative session by the same physician, the additional or secondary procedure or service must be identified by adding modifier 51 to the procedure or service code. See the *Surgical Services* module for additional information.

Modifier 59

Research shows that modifier 59 is often used incorrectly. Modifier 59 indicates that a provider performed a distinct procedure or service on the same day as another procedure or service. It identifies procedures and services that are not normally reported together, but are appropriate under the circumstances. Modifier 59 should be used only when there is no other modifier to correctly clarify the procedure or service. A distinct procedure may represent the following:

- A different session or patient encounter

- A different procedure or surgery

- A different site or organ system

- A separate incision or excision

- A separate lesion

- A separate injury or area of injury in extensive injuries

If multiple units of the same procedure are performed during the same session, the provider should report all the units on a single detail line, unless otherwise specified in medical policy.

Modifiers LT and RT

The modifiers LT (left) and RT (right) apply to codes that identify procedures that can be performed on paired organs such as ears, eyes, nostrils, kidneys, lungs, and ovaries. Modifiers LT and RT should be used whenever a procedure is performed on ***only one side*** to identify which one of the paired organs was operated on. The CMS requires these modifiers whenever appropriate.

Transportation Modifiers

Specific modifiers are used to report transportation services on claims. See the *[Transportation Services](#)* module for a list of the transportation origin and destination modifiers.

Using Modifiers with Pathology Codes

Some pathology codes have both professional and technical components. When submitting claims, use of a modifier depends on whether the entity reporting the service is reporting:

- The professional services of a pathologist only (billed with modifier 26 added to the code)

- The technical component of a laboratory only (billed with the TC modifier added to the code)

- Reporting both the professional and technical components as a global code (billed without any modifier)

In all instances, the first claim received in the system for a particular pathology code on a single date of service is the first one considered for payment.

National Drug Codes

The *Federal Deficit Reduction Act of 2005* mandates that the IHCP require the submission of National Drug Codes (NDCs) on claims submitted with certain procedure codes for physician-administered drugs. This mandate affects all providers submitting institutional claims (*UB-04* paper claim form, Portal institutional claim, and 837I electronic transaction) or professional claims (*CMS-1500* paper claim form, Portal professional claim, and 837P electronic transaction) for applicable procedure-coded drugs. Because the State may pay up to the 20% Medicare B copayment for dually eligible individuals, the NDC is also required on Medicare and Medicare Replacement Plan crossover claims for all applicable procedure codes.

For a list of affected codes, see *Procedure Codes That Require National Drug Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. All providers are encouraged to monitor future IHCP bulletins and banner pages for updates about NDC reporting.

For billing purposes, the NDC must be configured as 11 digits, using what is referred to as a "5-4-2" format: the first segment must include five digits, the second segment must include four digits, and the third segment must include two digits. If the product label displays an NDC with fewer than 11 digits, a zero must be added at the beginning of the appropriate segment to achieve the 5-4-2 format. Hyphens and spaces are omitted when submitting the NDC number on a claim. For example, if a package displays an NDC as 12345-1234-1, a zero must be added to the beginning of the third segment to create an 11-digit NDC as follows: 12345123401.

In addition to the NDC itself, providers must also submit the NDC description, NDC unit of measure, and NDC quantity. For details about entering NDC information on paper claim forms, see the *UB-04 Claim Form – Field-by-Field Instructions* and *CMS-1500 Claim Form – Field-by-Field Instructions* sections of this module.

Claims for procedure-coded, physician-administered drugs are priced using the submitted procedure code and procedure code units. The sole exception is that manually priced J and Q codes are priced using the submitted NDC. See the *Injections, Vaccines, and Other Physician-Administered Drugs* module for more information.

Single Procedure Code with Multiple NDCs

When billing a single procedure code that involves multiple NDCs, providers do not need to use the KP and KQ modifiers. Providers bill the claim with each appropriate NDC for the drug they are dispensing or administering on a separate detail line, repeating the HCPCS code as needed for each unique NDC code.

For example, a 50 mg vial of Synagis and a 100 mg vial of Synagis have different NDCs but the same procedure code. Therefore, if a provider administers 150 mg of Synagis using these two vials, the item would be billed with two detail lines for the same procedure code, and the appropriate NDC would be entered on each line.

Compounds with NDCs

When billing any compound drugs that require an NDC, providers must bill the appropriate NDCs for each procedure code. Providers receive payment for all valid NDCs included in the compound drug.

Place-of-Service Codes

Place-of-service (POS) codes are two-digit codes identifying the type of location where a service was provided. POS codes are required on all professional and dental claims. For a list of POS codes, see the *Place of Service Code Set* page on the CMS website at cms.hhs.gov.

Date of Service Definition

All claims must reflect a date of service. The date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. For example, when billing for the provision of dentures, the date of service on the claim must reflect the date the dentures are delivered to the patient. This requirement is applicable to all IHCP-covered services.

Visit and Encounter Definitions

The IHCP defines an office *visit* as a face-to-face encounter between a patient and a physician or other provider.

The IHCP considers multiple services a provider performs during the same visit for the same or related diagnosis to be a *single encounter*, even though the provider can consider them separate encounters if billed independently. For example, if a patient receives a dental exam and an amalgam during the same visit, the IHCP considers this a single encounter.

The IHCP considers multiple visits that occur within the same 24-hour period to be a single encounter if they are for the same or related diagnosis. The IHCP considers multiple visits to be multiple encounters if the diagnoses are different. For example, if the patient has an office visit in the morning and returns later the same day with the same or related diagnosis, the IHCP considers the two instances as a single encounter. However, if a patient has an office visit in the morning and returns later the same day for treatment of a new fracture, two different encounters have occurred.

When two valid providers (such as a medical provider and a mental health provider) see the same patient on the same day, the principal diagnoses should not be the same.

When billing a visit code, providers can bill only one unit of service per detail line of the claim. When visits occur on consecutive days, providers should bill each day on a separate line. When a member has more than one visit per day for the same provider, and the diagnoses are different, the IHCP requires a claim review for payment determination.

Therefore, providers should submit proper documentation along with the claim to substantiate the need for additional visits. This documentation includes, but is not limited to, the following:

- Visits performed at separate times of the day that indicate the times and the reasons for each visit on the face of the claim or on a claim attachment

- Visits provided by different providers on the same day that indicate the type of provider that rendered each visit and denote which practitioner treated which diagnosis

- Documentation in writing from the medical record that supports the medical reasons for the additional visit, including presenting symptoms or reasons for the visit, onset of symptoms, and treatment rendered

- Documentation that the diagnosis for each encounter is different

Calendar-Year Versus 12-Month Monitoring Cycle

Some IHCP service limitations are monitored via a rolling 12-month period, and some are monitored on a calendar-year basis. During claim processing, *Core*MMIS reviews the claim history to ensure services do not exceed established limitations. *Core*MMIS compares the service date for a particular claim with service dates that are already paid. *Core*MMIS *looks back* at service dates within the particular code's established service limitation. If the number of services or dollars has been exceeded for a specific benefit limit, prior authorization (PA) may be required based on medical necessity. If PA is not obtained, *Core*MMIS rejects the claim. In summary, *Core*MMIS generally *rolls back* 1 year from the service date and counts the number of units or dollars used. *Core*MMIS calculates benefit limits on a service-date-specific basis for paid claims.

Example 1: This example illustrates a calendar-year monitoring cycle. IHCP members are authorized office visits at 30 per calendar year. A member became eligible on February 1, 2019, and with four office visits per month (to a physician, chiropractor, podiatrist, and mental health provider), reaches the 30-office-visit limitation in September 2019. Without PA, the member is not authorized for another office visit until January 1, 2020 (the beginning of a new calendar year), at which point the restriction of 30 visits per calendar year is restored.

Example 2: This example illustrates a rolling 12-month monitoring cycle. The IHCP limits coverage of mental health services provided in an outpatient or office setting to 20 units per member, per provider, per rolling 12-month period without prior authorization. A member became eligible on February 1, 2019, and received four units of outpatient mental health services on the first day of eligibility. On September 1, 2019, the member reached the 20-unit limitation. Without PA, the member is not authorized for another outpatient mental health service until February 1, 2020. In this example of a 12-month limitation, the system restores the four units depleted on September 1, 2019, 12 months (or 365 days) after the date they were used. In this illustration, if the member does not use another outpatient mental health service until all 20 units are restored, the full complement of 20 units per rolling 12-month period would be totally restored in September 2020.

The following are examples of services that are limited on a **calendar-year** basis:

- Office visits

- Inpatient rehabilitation

- Durable medical equipment (DME) and home medical equipment (HME)

- Chiropractic

- Vision

The following are examples of services that are limited on a **rolling 12-month** basis:

- Mental health visits

- Transportation

- Incontinence supplies

Section 2: Institutional Claim Billing Instructions

This section provides information about submitting institutional claims using the *UB-04 Uniform Bill* (*UB-04*) claim form or its *Health Insurance Portability and Accountability Act* (HIPAA)-compliant electronic equivalents: the *837 Health Care Claim: Institutional* (837I) transaction and the Provider Healthcare Portal (Portal) institutional claim.

The instructions for completing the *UB-04* paper claim form align with the electronic claim requirements mandated by the HIPAA Administrative Simplification requirements.

Types of Services Billed on Institutional Claims

Table 3 shows the provider types and the types of services that can be billed on the *UB-04* claim form, Portal institutional claim, or 837I transaction.

Table 3 – Types of Services Billed on an Institutional Claim

Provider Type	Type of Services
Ambulatory surgical center (ASC) (Type 02)	Outpatient surgical services
Birthing center (Type 08, specialty 088)	Normal pregnancy delivery services (vaginal only)
End-stage renal disease (ESRD) clinic (Type 30)	Renal dialysis services
Home health agency (HHA) (Type 05)	Home health services
Hospice (Type 06)	Hospice facility services (except waiver services)
Hospital (Type 01)	Inpatient facility services (acute care, psychiatric, rehabilitation, and long-term acute care [LTAC])
	Outpatient facility services
	Renal dialysis services
	Outpatient radiological services (technical component)
	Outpatient laboratory services (technical component)
Long-term care (LTC)/extended care facility (Type 03, specialties 030–033)	Nursing facility (NF) services
	Intermediate care facility for individuals with intellectual disability (ICF/IID) facility services
	Community residential facility for the developmentally disabled (CRF/DD) facility services (this type of facility may also be called a small ICF/IID)
Rehabilitation facility (Type 04, specialty 040)	Rehabilitation facility services
	Traumatic brain injury services

> *Note:* *Hospital pharmacy take-home, direct care services performed by a physician, and transportation services provided in a hospital are not billed on institutional claims.*

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Admission and Duration Requirements for Institutional Claims

The following requirements apply to the *UB-04* claim form, Portal institutional claim, and 837I transaction:

- Always include admitting and principal diagnosis codes for inpatient claims.

- Always enter accommodation rates in whole units.

- A day begins at midnight and ends 24 hours later.

- Any part of a day, including the day of admission, counts as a full day, with the following exceptions:
  - The day of discharge is not counted as a day unless the member is readmitted to the hospital by midnight on the same day.
  - The day of death is the day of discharge and is not counted for inpatient or LTC services.
  - Hospice services can include the day of death as a billable date for the hospice portion of the claim when the member resides in a nursing facility. The date of discharge or death is not payable for the room-and-board portion of the hospice claim when the member resides in a nursing facility.

- A period of inpatient care that includes at least 1 night in a hospital and is reimbursable under the IHCP is generally considered an *inpatient stay*; however, if the admission lasts fewer than 24 hours, the stay is considered an *outpatient service*. See the *[Inpatient Hospital Services](#)* module for more information.

Using Modifiers for Outpatient Hospital Billing

Modifiers may be appended to Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes only when clinical circumstances justify the use of the modifier. Institutional claims must incorporate the correct use of modifiers. A modifier should not be appended to a HCPCS/CPT code solely to bypass Component Rebundling auditing. The use of modifiers affects the accuracy of claim billing, reimbursement, and Component Rebundling auditing. If multiple units of the same procedure are performed during the same session, the provider should roll all the units to a single line, unless otherwise specified in medical policy.

The IHCP implemented enhanced code auditing into the claim-processing system. This enhanced code auditing supports the efforts of the Family and Social Services Administration (FSSA) to promote and enforce correct coding efforts for more appropriate and accurate program reimbursement. See the *[Modifiers](#)* section of this document for general information about the use of modifiers.

Using ICD Procedure Codes for Inpatient Billing

The International Classification of Diseases (ICD) system includes two types of codes: diagnosis codes (also known as ICD Clinical Modification, or ICD-CM, codes) and procedure codes (also known as ICD Procedure Coding System, or ICD-PCS, codes). The IHCP restricts the use of ICD procedure codes on institutional claims to the reporting of inpatient procedures. ICD procedure codes billed on institutional claims *other than* inpatient claims will deny with explanation of benefits (EOB) 4072 − *ICD CM procedure code not allowed for claim type billed per HIPAA regulations. Please verify and resubmit claim as appropriate.*

Claims that deny with EOB code 4072 should be corrected to remove ICD procedure codes and resubmitted for reimbursement consideration.

Revenue Codes

Revenue codes are used on institutional billing claims. Providers must use the appropriate revenue code descriptive of the service or of the setting where the service was delivered. For a table of revenue codes with descriptions, see *Revenue Codes*, accessible from the *[Code Sets](#)* page at in.gov/medicaid/providers. For outpatient reimbursement information for applicable revenue codes, see the current Outpatient Fee Schedule, accessible from the *[IHCP Fee Schedules](#)* page at in.gov/medicaid/providers.

Revenue Codes Not Reimbursable for Outpatient Billing

As indicated in the Outpatient Fee Schedule, some revenue codes are noncovered for outpatient billing. Note that the IHCP excludes outpatient reimbursement for certain codes that national coding guidelines might indicate are appropriate in an outpatient setting. These revenue codes may still be valid in other institutional settings, such as inpatient, hospice, LTC, or home health.

Using Treatment Room Revenue Codes for Therapeutic and Diagnostic Injections

Therapeutic and diagnostic injections (including infusions) are performed within a number of treatment centers in a hospital, including, but not limited to, an operating room (360), emergency room (450), or clinic (510). **Similar to Medicare policy, IHCP policy requires that hospitals report these injections under the revenue code for the treatment center where injections are performed**. This policy is also consistent with rate setting for treatment rooms, because costs for injections are considered when establishing treatment room rates. Injections are included in the reimbursement of the treatment room when other services are provided.

If a patient receives *only* an injection service, and no other service is provided, the provider is instructed to bill only the administration code using revenue code 260 – *IV Therapy-General*. Consistent with national coding guidelines that indicate infusion administration should be billed with revenue code 260, the IHCP considers infusions to be a stand-alone service. When performed in conjunction with other services in a treatment room, providers may bill the infusion administration code along with revenue code 260 on a separate line from the treatment room. When performing only an infusion, providers may bill only the administration code along with revenue code 260. See the following section for more information about using revenue code 260. See the *[Outpatient Facility Services](#)* module for more information about treatment room billing.

Revenue Codes Linked with Specific Procedure Codes

Providers should follow national guidelines for appropriate use of procedure codes with the revenue code billed. IHCP exceptions to the standard revenue code linkages follow. For lists of procedure codes linked to each of the following revenue codes, see *Revenue Codes with Special Procedure Code Linkages*, accessible from the *[Code Sets](#)* page at in.gov/medicaid/providers. All claims are subject to postpayment review.

Revenue Code 260 – *IV Therapy – General*

The IHCP designates specific procedure codes that can be billed with revenue code 260 – *IV therapy – General* to receive separate reimbursement when billed on the same date of service as a treatment room revenue code. Injection administration (including vaccine administration) is included in the reimbursement for treatment rooms. See the *[Outpatient Facility Services](#)* module for more information.

> *Note:* If an injection or infusion service is the **only** service rendered on a particular date, providers are reminded that they should **not** bill a treatment room revenue code, but instead should bill only revenue code 260, along with any procedure code appropriate for billing with revenue code 260 per the national coding guidelines. See the *Using Treatment Room Revenue Codes for Therapeutic and Diagnostic Injections* section for details.

Revenue Code 274 – *Prosthetic/Orthotic Devices*

The IHCP designates specific procedure codes that may be reimbursed in the outpatient setting when billed with revenue code 274 – *Prosthetic/orthotic devices*. No other codes will be reimbursed when billed with revenue code 274, and revenue code 274 will not be reimbursed when billed without a procedure code listed on the *Procedure Codes Linked to Revenue Code 274 – Prosthetic/Orthotic Devices* table in *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers. See the *Durable and Home Medical Equipment and Supplies* module for more information.

Revenue Code 636 – *Drugs Requiring Detailed Coding*

The IHCP designates specific procedure codes that may be separately reimbursed in the outpatient setting when billed with revenue code 636 – *Drugs requiring detailed coding*. No other codes will be reimbursed when billed with revenue code 636, and revenue code 636 will not be reimbursed when billed without a code listed on the *Procedure Codes Linked to Revenue Code 636 – Drugs Requiring Detailed Coding* table in *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Revenue Code 724 – Labor Room/Delivery – Birthing Center

The IHCP designates one procedure code that may be separately reimbursed when billed with revenue code 724 – *Birthing center*. No other procedure codes will be reimbursed when billed with revenue code 724. See the *Obstetrical and Gynecological Services* module for more information.

Revenue Code 920 – *Other Diagnostic Services – General*

The IHCP designates specific procedure codes that may be separately reimbursed in the outpatient setting when billed with revenue code 920 – *Other diagnostic services – general*. No other codes will be reimbursed when billed with revenue code 920, and revenue code 920 will not be reimbursed when billed without a code listed on the *Procedure Codes Linked to Revenue Code 920 – Other Diagnostic Services – General* table in *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Revenue Code 929 – *Other Diagnostic Services*

The IHCP designates specific procedure codes that may be separately reimbursed in the outpatient setting when billed with revenue code 929 – *Other diagnostic services*. No other codes will be reimbursed when billed with revenue code 929, and revenue code 929 will not be reimbursed when billed without a code listed on the *Procedure Codes Linked to Revenue Code 929 – Other Diagnostic Services* table in *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Revenue Code 940 – *Other Therapeutic Services – General*

The IHCP designates specific procedure codes that may be separately reimbursed in the outpatient setting when billed with revenue code 940 – *Other therapeutic services – general*. No other codes will be reimbursed when billed with revenue code 940, and revenue code 940 will not be reimbursed when billed without a code listed on the *Procedure Codes Linked to Revenue Code 940 – Other Therapeutic Services – General* table in *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Revenue Code Linkages for Managed Care Billing Only

For MCEs only, the IHCP designates specific procedure codes that may be separately reimbursed in the outpatient setting when billed with the following revenue codes:

- Revenue code 912 – Behavioral health treatments/services – Partial hospitalization – Less intensive

- Revenue code 913 – Behavioral health treatments/services – Partial hospitalization – Intensive

- Revenue code 960 – Professional fees (see also 097X and 098X) – General

No other procedure codes will be reimbursed when billed with the revenue codes indicated, and the revenue codes indicated will not be reimbursed when billed without the procedure codes listed on the *Procedure Codes Linked to Revenue Codes for Managed Care Billing Only* table in *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

These revenue codes are noncovered for FFS claims.

Guidelines for Completing the *UB-04* Claim Form

> Note: The instructions provided in this section apply to the IHCP guidelines only and are not intended to replace instructions issued by the National Uniform Billing Committee (NUBC). The NUBC official UB-04 instruction manual is available by subscription from the *NUBC website* at nubc.org.

This section provides a brief overview of the instructions to complete the *UB-04* claim form. Noncompliant *UB-04* paper claims are returned to the provider. For instructions about National Provider Identifier (NPI) requirements, see the *National Provider Identifier and One-to-One Match* section of this document.

> Note: Providers are required to use the standard red-ink form for paper submission. Claims submitted on black-and-white copies of the UB-04 claim form will be returned, and providers will have to resubmit the claim on the official red claim form.

UB-04 Claim Form – Field-by-Field Instructions

Table 4 provides basic information about completing the fields (or *data elements*) on the *UB-04* claim form. Where necessary, the table also notes specific directions applicable to a particular provider type. Some fields are required to be completed, while others are optional. *Required* or *required, if applicable* fields are indicated by **bold type**. *Optional* and *not applicable* fields are displayed in normal type. The table refers to each field by the corresponding number (or *form locator*) used on the form. Providers should use the NUBC *UB-04* billing conventions unless otherwise specified.

Figure 7 shows a sample copy of the *UB-04* claim form.

Table 4 – *UB-04* Claim Form Fields

Form Field	Narrative Description/Explanation
1	**[SERVICE LOCATION INFORMATION]** – Enter the *service location* name and address (including the expanded ZIP Code+4) where the patient was seen (this address must match the service location address currently on file with the IHCP for the group or billing provider where the service was rendered). **Required.** *Note: If the U.S. Postal Service provides an expanded ZIP Code for a geographic area, this expanded ZIP Code must be entered on the claim form.*
2	UNLABELED FIELD – Not applicable.
3a	PAT CNTL # – Enter the internal patient control (tracking) number. Optional.
3b	MEDICAL REC # – Enter the number assigned to the patient's medical or health record by the provider. Optional.
4	**TYPE OF BILL** – Enter the code indicating the specific type of bill. This four-digit code requires a leading zero plus one digit from each of the four categories, written in the following sequence: • First position – Zero • Second position – Type of Facility • Third position – Bill Classification • Fourth position – Frequency For example, the type-of-bill code for hospice is 0822. All positions must be fully coded. **Required.** *Note: A current list of type of bill codes is available from the NUBC by subscription. See the [NUBC website](#) at nubc.org. The NUBC maintains this code set, which is considered an external code set by HIPAA requirements. Therefore, the IHCP is not responsible for updating the type of bill code set. It is the provider's responsibility to monitor the changes made to this external code set.*
5	FED. TAX NO. – Not applicable.
6	**STATEMENT COVERS PERIOD, FROM/THROUGH** – Enter the beginning and ending service dates included on this bill. Indicate dates in MMDDYY format, such as 012518. **Required.** *Note: For inpatient claims that include charges for outpatient services that were provided within 3 days preceding the admission, the From date in this field should be the date of the earliest outpatient service detail on the claim.*
7	UNLABELED FIELD – Not applicable.
8a	PATIENT NAME [IDENTIFIER] – Not applicable. Report the IHCP Member ID (also known as RID) in field 60.
8b	**PATIENT NAME** – Last name, first name, and middle initial of the member. **Required.**
9a	PATIENT ADDRESS [STREET] – Enter the member's street address. Optional.
9b	PATIENT ADDRESS [CITY] – Enter the member's city. Optional.
9c	PATIENT ADDRESS [STATE] – Enter the member's two-alpha-character state abbreviation. Optional.
9d	PATIENT ADDRESS [ZIP CODE] – Enter the member's ZIP Code. Optional.

Form Field	Narrative Description/Explanation
9e	PATIENT ADDRESS [COUNTRY CODE] – Enter the three-character country code, if other than USA. Optional.
10	BIRTHDATE – Enter the member's date of birth in an MMDDYYYY format. Optional.
11	SEX – Enter the member's gender. M for male, F for female. Optional.
12	**ADMISSION DATE** – Enter the date the patient was admitted to inpatient care in a MMDDYY format. **Required for inpatient and LTC.**
13	**ADMISSION HR** – Enter the code indicating the hour during which the patient was admitted for inpatient care**. Required for inpatient.**

Admission Hour Code Structure			
Code	**Time Frame**	**Code**	**Time Frame**
00	12 a.m. – 12:59 a.m.	12	12 p.m. – 12:59 p.m.
01	1 a.m. – 1:59 a.m.	13	1 p.m. – 1:59 p.m.
02	2 a.m. – 2:59 a.m.	14	2 p.m. – 2:59 p.m.
03	3 a.m. – 3:59 a.m.	15	3 p.m. – 3:59 p.m.
04	4 a.m. – 4:59 a.m.	16	4 p.m. – 4:59 p.m.
05	5 a.m. – 5:59 a.m.	17	5 p.m. – 5:59 p.m.
06	6 a.m. – 6:59 a.m.	18	6 p.m. – 6:59 p.m.
07	7 a.m. – 7:59 a.m.	19	7 p.m. – 7:59 p.m.
08	8 a.m. – 8:59 a.m.	20	8 p.m. – 8:59 p.m.
09	9 a.m. – 9:59 a.m.	21	9 p.m. – 9:59 p.m.
10	10 a.m. – 10:59 a.m.	22	10 p.m. – 10:59 p.m.
11	11 a.m. – 11:59 a.m.	23	11 p.m. – 11:59 p.m.

Form Field	Narrative Description/Explanation
14	**ADMISSION TYPE** – Enter the code indicating the priority of this admission. **Required for inpatient, outpatient, and LTC.**

Admission Codes	
Code	**Description**
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
9	Unspecified

Form Field	Narrative Description/Explanation
15	**ADMISSION SRC** – Enter the source of the admission. **Required for the receiving hospital for inpatient transfers (use admission source code 4)**.
16	DHR – Enter the discharge hour (the hour during which the member was discharged from inpatient care). Valid values are the same as for field 13. Optional.

Form Field	Narrative Description/Explanation
17	**STAT** – Enter the patient status code indicating the member's discharge status as of the ending service date of the period covered on this bill. **Required for inpatient, outpatient, LTC, home health care, and hospice.**

<table>
<tr><td colspan="2" align="center">Patient Status Codes</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>01</td><td>Discharged to home or self-care, routine discharge</td></tr>
<tr><td>02</td><td>Discharged or transferred to another short-term general hospital for inpatient care</td></tr>
<tr><td>03</td><td>Discharged or transferred to skilled nursing facility (SNF)</td></tr>
<tr><td>04</td><td>Discharged or transferred to a facility that provides custodial or supportive care</td></tr>
<tr><td>05</td><td>Discharged or transferred to a designated cancer center or children's hospital</td></tr>
<tr><td>06</td><td>Discharged or transferred to home under care of organized home health service organization</td></tr>
<tr><td>07</td><td>Left against medical advice or discontinued care</td></tr>
<tr><td>20</td><td>Expired</td></tr>
<tr><td>21</td><td>Discharged or transferred to court or law enforcement</td></tr>
<tr><td>30</td><td>Still a patient</td></tr>
<tr><td>40</td><td>Expired at home</td></tr>
<tr><td>41</td><td>Expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice</td></tr>
<tr><td>42</td><td>Expired – place unknown</td></tr>
<tr><td>43</td><td>Discharged or transferred to a federal healthcare facility</td></tr>
<tr><td>50</td><td>Discharged to hospice – Home</td></tr>
<tr><td>51</td><td>Discharged to hospice – Medical facility</td></tr>
<tr><td>61</td><td>Discharged or transferred within this institution to hospital-based Medicare swing bed</td></tr>
<tr><td>62</td><td>Discharged or transferred to another rehabilitation facility, including rehabilitation distinct part units of a hospital</td></tr>
<tr><td>63</td><td>Discharged or transferred to a long-term care hospital</td></tr>
<tr><td>64</td><td>Discharged or transferred to a nursing facility – Medicaid-certified but not Medicare-certified</td></tr>
<tr><td>65</td><td>Discharged or transferred to a psychiatric hospital or psychiatric unit of a hospital</td></tr>
<tr><td>66</td><td>Discharged or transferred to a critical access hospital</td></tr>
<tr><td>70</td><td>Discharged or transferred to another type of healthcare institution not defined elsewhere in the code list</td></tr>
<tr><td>81</td><td>Discharged to home or self-care with a planned acute care hospital inpatient readmission</td></tr>
<tr><td>82</td><td>Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission</td></tr>
<tr><td>83</td><td>Discharged/transferred to skilled nursing facility with Medicare certification with a planned acute care hospital inpatient readmission</td></tr>
<tr><td>84</td><td>Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission</td></tr>
<tr><td>85</td><td>Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission</td></tr>
</table>

Form Field		Narrative Description/Explanation
	86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
	87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
	88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
	89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
	90	Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission
	91	Discharged/transferred to a Medicare certified long-term care hospital with a planned acute care hospital inpatient readmission
	92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission
	93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
	94	Discharged/transferred to a critical access hospital with a planned acute care hospital inpatient readmission
	95	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission
18–24 Seven maximum allowed	**CONDITION CODES** – Enter the applicable codes to identify conditions relating to this bill that may affect processing. A maximum of seven codes can be entered. **Required, if applicable.** The IHCP allows any valid condition code including and not limited to:	
	Code	**Description**
	02	Condition is employment related
	03	Patient covered by insurance not reflected here
	05	Lien has been filed
	07	Treatment of nonterminal condition for hospice patient
	40	Same-day transfer
	61	Cost outlier
	81	C-section/inductions < 39 weeks – medical necessity
	82	C-section/inductions < 39 weeks – elective
	83	C-section/inductions 39 weeks or greater
	A7	Induced abortion, danger to life
	A8	Induced abortion, victim of rape or incest
25–28	CONDITION CODES – Not used.	
29	ACDT STATE – Enter the state where the accident occurred. Optional.	
30	UNLABELED FIELD – Not applicable.	

Form Field	Narrative Description/Explanation
31a–34b	**OCCURRENCE CODE/DATE** – Enter the applicable code and associated date to identify significant events relating to this bill that may affect processing. Dates are entered in an MMDDYY format. A maximum of eight codes and associated dates can be entered. **Required, if applicable.** The IHCP uses the following occurrence codes:

Occurrence Codes	
Code	**Description**
01	Auto accident
02	No-fault insurance involved – *This code includes auto accident or other insurance.*
03	Accident or tort liability
04	Accident or employment related
05	Other accident
06	Crime victim
25	Date benefits terminated by primary payer
27	Date home health plan established or last reviewed
42	Date of discharge – *This code is used to show the date of live discharge from an inpatient hospital stay, from a long-term care facility, or from home health care or hospice, as appropriate.*
52	Certification/recertification date – *This code is used to show that an initial examination or initial evaluation is being billed in a hospital setting. This code bypasses certain PA editing. Details can be found in the applicable sections of the IAC.*
55	Date of death – This code is used to show the date of death.
73	Benefit eligibility – *This code is used to bill for home health overhead – One per day.*

Form Field	Narrative Description/Explanation
35a–36b	OCCURRENCE SPAN CODE, FROM/THROUGH – Enter the code and associated dates for significant events relating to this bill. Each occurrence span code must be accompanied by the span *from* and *through* date. Optional.
37	UNLABELED FIELD – Not applicable.
38	UNLABELED FIELD – Not applicable.
39a–41d	**VALUE CODES – CODE/AMOUNT** – Use these fields to identify Explanation of Medicare Benefits (EOMB) or Medicare Replacement Plan EOB information. The following value codes must be used along with the appropriate dollar or unit amounts for each. **Required, if applicable.** • Value code A1 – Medicare deductible amount • Value code A2 – Medicare coinsurance or copayment amount • Value code 06 – Medicare blood deductible amount • Value code 80 – IHCP covered days *Note: For outpatient and home health crossover claims submitted on the UB-04 paper claim form, providers are also required to complete and submit the IHCP Third-Party Liability (TPL)/Medicare Special Attachment Form in conjunction with claim. The form should include the itemized coinsurance, copayment, deductibles, and blood deductible applied at the detail level. The form and instructions for completing it are available on the Forms page at in.gov/medicaid/providers.*

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Version: 5.0

Form Field	Narrative Description/Explanation
	The UB-04 claim form includes 22 lines for fields 42–47. For continuation claims, see the [Billing a Continuation Claim Using the UB-04 Claim Form](#) section of this document
42	**REV. CD.** – Enter the applicable revenue codes that identify each specific accommodation, ancillary service, or billing calculation. The appropriate three-digit, numeric revenue code must be entered to explain each charge entered in field 47. See the IAC for covered services, limitations, and medical policy rules. Use the most specific revenue code available. **Required.** *Note: For a list of revenue codes with descriptions, see Revenue Codes, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.*
43	**DESCRIPTION** – Enter a narrative description of the related revenue code category (entered in field 42). Abbreviations may be used. Only one description per line. Optional. For National Drug Code (NDC) billing for revenue codes 634, 635, and 636, the following information is **required when applicable**: 1. Enter the NDC qualifier of N4 in the first two positions on the left side of the field. 2. Enter the 11-digit numeric NDC code in the "5-4-2" format. Do not include spaces or hyphens. 3. Enter the drug description. 4. Enter the NDC unit-of-measure qualifier: – F2 – International Unit – GR – Gram – ME – Milligram – ML – Milliliter – UN – Unit 5. Enter the NDC quantity (administered amount) with up to three decimal places, such as 1234.567.
44	**HCPCS/RATE/HIPPS CODE** – Enter the HCPCS code applicable to the service provided. Only one service code per line is permitted. **Required for home health, outpatient, and ASC services.** This field is also used to identify procedure code modifiers. Provide the appropriate modifier, as applicable. Up to four modifiers are allowed for each procedure code. This is a 13-character field. **Required, if applicable.**
45	**SERV. DATE** – Provide the date the indicated outpatient service was rendered. **Required for home health, hospice, ESRD, ASC, and outpatient.** **CREATION DATE –** In field 45, line 23, Enter the date the bill is submitted. **Required.**
46	**SERV. UNITS** – Enter the number of units provided for each corresponding revenue code or procedure code submitted. Six digits are allowed. Units must be billed using whole numbers. **Required.**
47	**TOTAL CHARGES** – Enter the total charges pertaining to the related revenue code for the STATEMENT COVERS PERIOD (field 6). Ten digits are allowed per line, such as 99999999.99. **Required.** **TOTALS** – In line 23 of this field, enter the sum of all charges billed. For continuation claims, the sum should be entered only on the last page of the claim. **Required.**
48	NON-COVERED CHARGES – Reflects noncovered charge amounts. Optional.
49	UNLABELED FIELD – Not applicable.

Form Field	Narrative Description/Explanation
	Fields 50A–55C and 58A–65C are for primary, secondary, and tertiary insurer information. Medicare or Medicare Replacement Plan is always listed first (row A), if applicable. Other TPL insurers are listed next, if applicable. The IHCP information is always listed last (see the [Third-Party Liability](#) module for exceptions).
50A–50C	**PAYER NAME** – Enter the name of the primary, secondary, and tertiary payer for the claim. Enter payers in the following order, starting at row A and using the next available row for each additional payer: - Enter "Medicare" or the name of the Medicare Replacement Plan. **Required, if applicable.** - Enter the third-party carrier's name and additional payer names. **Required, if applicable.** - Enter the applicable IHCP payer: Medicaid or 590 Program. **Required.**
51A–51C	**HEALTH PLAN ID** – Enter plan ID numbers pertaining to Medicare and TPL payers listed in field 50. **Required, if applicable, for Medicare and TPL rows.** - Not applicable for the Medicaid or 590 Program row.
52A–52C	REL INFO – Not applicable.
53A–53C	ASG BEN – Mark **Y** for yes, benefits assigned. The *IHCP Provider Agreement* includes details about accepting payment for services. Optional.
54A–54C	**PRIOR PAYMENTS** – Enter the amount paid by each carrier listed in fields 50A–50C. **Required, if applicable.** *Note:* *For outpatient and home health claims submitted on the UB-04 paper claim form, if another insurer made a payment on the claim (including payments of zero), the [IHCP TPL/Medicare Special Attachment Form](#) is required to be completed and submitted in conjunction with the claim. The form should include all prior TPL and Medicare payments at the detail level. The form and instructions for completing it are available on the [Forms](#) page at in.gov/medicaid/providers.* *If a TPL or Medicare carrier made a payment on the claim, the explanation of benefits (EOB) is not required. For requirements related to IHCP claims when the primary carrier denied the claim or paid at zero, see the [Documenting Denied or Zero-Paid Claims](#) section.*
55A–55C	**EST. AMOUNT DUE** – In the appropriate row, enter the amount being billed to the IHCP. Calculate the estimated amount due by subtracting the amounts in fields 54A–54C from the amount in row 23 of field 47, TOTAL CHARGES > TOTALS. This field accommodates 10 digits, such as 99999999.99. - Not applicable for Medicare or TPL rows. **Required in Medicaid or 590 Program row.**
56	**NPI** – Enter the 10-digit NPI for the billing provider. **Required for healthcare providers.** *Note: The billing provider's taxonomy code should be entered in field 81CCa.*
57A–57C	**OTHER PROVIDER ID** – Enter an additional provider identification number for the payers listed in field 50: - Optional for Medicare or TPL payer rows. - In the Medicaid or 590 Program payer row, enter the IHCP-assigned Provider ID for the billing provider. **Required for atypical providers.**

Form Field	Narrative Description/Explanation
58A–58C	**INSURED'S NAME** – Enter the last name, first name, and middle initial of the individual insured by the payers listed in field 50. **Required, if applicable. IHCP member name is required.**
59A–59C	P. REL – Not applicable.
60A–60C	**INSURED'S UNIQUE ID** – Enter the member's identification number for the respective payers entered in fields 50A–50C. **Required, if applicable. The 12-digit IHCP Member ID is required.**
61A–61C	**GROUP NAME** – Enter the name of the group or plan through which insurance is provided to the member by the respective payers entered in fields 50A–50C. **Required, if applicable.**
62A–62C	**INSURANCE GROUP NO.** – Enter the identification number, control number, or code assigned by the carrier or administrator (listed in field 50) to identify the group under which the individual is covered: • **Required, if applicable, for Medicare and TPL rows.** • Not applicable for the Medicaid or 590 Program row.
63A–63C	TREATMENT AUTHORIZATION CODES – Enter the number that indicates the payer authorized the treatment covered by this bill. Optional.
64A–64C	DOCUMENT CONTROL NUMBER – Not applicable.
65A–65C	**EMPLOYER NAME** – Enter the name of the employer that might or does provide healthcare coverage for the insured individual identified in field 58. **Required, if applicable.**
66	**DX** – Enter **0** to indicate ICD-10 codes. **Required.**
67	**[PRINCIPAL DIAGNOSIS CODE]** – Provide the ICD code describing the *principal diagnosis*; that is, the condition established after study to be chiefly responsible for the admission of the patient for care. **Required.** **[POA INDICATOR]** – Enter the appropriate present-on-admission (POA) indicator in the shaded area of field 67. **Required for inpatient (except for codes that are exempt from POA reporting).** Valid POA indicators include: • **Y** (for yes) – Present at the time of inpatient admission. • **N** (for no) – Not present at the time of inpatient admission. • **U** (for unknown) – The documentation is insufficient to determine if the condition was present at the time of inpatient admission. • **W** (for clinically undetermined) – The provider is unable to clinically determine whether the condition was present at the time of inpatient admission. • **[Leave blank]** (for unreported/not used) – Diagnosis is exempt from POA reporting. *Note: A list of diagnosis codes that are exempt from POA reporting can be accessed from the [ICD-10-CM](#) page at cdc.gov. For inpatient claims, leave the POA indicator blank only for codes on that list.*

Form Field	Narrative Description/Explanation
67A–Q	**[OTHER DIAGNOSIS CODES]** – Provide the ICD codes corresponding to additional conditions that coexist at the time of admission, or that develop subsequently, and that have an effect on the treatment received or the length of stay. **Required, if applicable.** **[POA INDICATOR]** – Enter the appropriate POA indicator in the shaded areas of field 67A–Q. **Required for inpatient (except for codes that are exempt from POA reporting).** Valid POA indicators include: **Y** (for yes) – Present at the time of inpatient admission. **N** (for no) – Not present at the time of inpatient admission. **U** (for unknown) – The documentation is insufficient to determine if the condition was present at the time of inpatient admission. **W** (for clinically undetermined) – The provider is unable to clinically determine whether the condition was present at the time of inpatient admission. **[Leave blank]** (for unreported/not used) – Diagnosis is exempt from POA reporting. *Note: A list of diagnosis codes that are exempt from POA reporting can be accessed from the* <ins>ICD-10-CM</ins> *page at cdc.gov. For inpatient claims, leave the POA indicator blank only for codes on that list.*
68	UNLABELED FIELD – Not applicable.
69	**ADMIT DX** – Enter the ICD diagnosis code provided at the time of admission, as stated by the physician. **Required for inpatient and LTC.**
70	**PATIENT REASON DX** – Enter the ICD diagnosis code that reflects the patient's reason for visit at the time of outpatient registration. **Required, when appropriate.**
71	PPS CODE – Not applicable.
72	**ECI** – If applicable, use the appropriate external cause of injury (ECI) diagnosis codes provided at the time of admission, as stated by the physician. ECI codes (also known as E codes) indicate the external cause of injury, poisoning, or adverse effect. Up to three ECI codes may be entered. **Required, if applicable.** The IHCP does not require a POA indicator in the ECI field. If a POA indicator is entered in this field, it will be ignored and not used for DRG grouping. Optional.
73	UNLABELED FIELD – Not applicable.
74	**PRINCIPAL PROCEDURE CODE/DATE** – Enter the ICD procedure code that identifies the principal procedure performed during the period covered by this claim, and the date the principal procedure described on the claim was performed. **Required for inpatient procedures.** Not allowed for any claim type other than inpatient claims.
74a–e	**OTHER PROCEDURE CODE/DATE** – Enter the ICD procedure codes identifying all significant procedures other than the principal procedure, and the dates the procedures were performed. Report the codes that are most important for the encounter and specifically any therapeutic procedures closely related to the principal diagnosis. **Required, when appropriate, for inpatient procedures.** Not allowed for any claim type other than inpatient claims.
75	UNLABELED FIELD – Not applicable.

Form Field	Narrative Description/Explanation
76	**ATTENDING – NPI** – Enter the attending physician's 10-digit numeric NPI. Do not use the NPI of a group provider. The attending provider should always be an individual person. **Required for inpatient, outpatient, ASC, and LTC.**
77	**OPERATING – NPI** – Enter the operating physician's 10-digit numeric NPI. **Required if any surgical codes are billed.**
78	**OTHER NPI** – Enter the 10-digit numeric NPI for the other physician (referring/primary medical provider [PMP]). **Required if the ordering, prescribing, or referring (OPR) physician is not listed in fields 76 or 77.**
79	OTHER – NPI – Not applicable.
80	REMARKS – Use this field for claim note text. Provide information, using as many as 80 characters, that may be helpful in further describing the services rendered. Optional. *Note: The REMARKS field is not used systematically for claim processing at this time, but may be used by the Claims Resolution Unit for more information if the claim suspends for review during processing.*
81CCa–d	**[ADDITIONAL CODES]** – Enter B3 taxonomy qualifier and corresponding 10-digit alphanumeric taxonomy code. **Required, if applicable.** Taxonomy may be needed to establish a one-to-one NPI/Provider ID match if the provider has multiple locations: 81CCa – First box *B3* qualifier, second box taxonomy code for billing provider from field 56 81CCb – Not applicable 81CCc – Not applicable 81CCd – Not applicable

Figure 7 – *UB-04* Claim Form

Billing a Continuation Claim Using the UB-04 Claim Form

Providers can prepare a *continuation claim*, which is a claim with more than one *UB-04* claim form completed as if it is one claim to be processed for payment by the IHCP. Continuation claims cannot contain more than 66 detail lines **or be more than three pages long**. Providers must complete the continuation claim as follows:

- Complete the first 22 lines for fields 42-47 on a *UB-04* claim form.

- Mark the *UB-04* claim form page numbers in the area provided on line 23 (PAGE __ of __).

- Do not subtotal the charges (field 47, line 23) on the first page of the claim; otherwise, *Core*MMIS reads the pages as separate claims rather than as a single claim.

- Complete subsequent *UB-04* claim forms (up to two additional pages) for the remaining services being billed.

- Provide a grand total for the continuation claim on the **last page** of the *UB-04* claim form (field 47, line 23).

Guidelines for Completing Institutional Claims Electronically

The IHCP accepts institutional claims submitted electronically through an 837I transaction or via the Portal.

Providers may submit as many as 27 ICD diagnosis codes on the 837I electronic transaction or Portal institutional claim, including admit, principal, external cause of injury (ECI), and 24 secondary diagnosis codes. The provider uses these codes to describe the medical condition of the patient, and the IHCP uses them to process the transaction. The IHCP processes the first 11 diagnosis codes, including the principal, admission, and additional diagnosis codes submitted.

*Core*MMIS accepts up to 450 service details (the maximum number of details for Medicare) on the 837I transaction or Portal institutional claim.

The following section provides a step-by-step example of the Portal claim-submission process for an institutional claim.

For information about completing an 837I electronic transaction, see the following resources:

- *Electronic Data Interchange* module

- *837I Implementation Guide,* available for purchase and download through the Washington Publishing Company website at wpc-edi.com

- 837I Companion Guide, available from the *IHCP Companion Guides* page at in.gov/medicaid/providers.

For general information about electronic billing, see the *Electronic Claims* section of this module.

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Portal Institutional Claim Submission Process

> *Note: For general information about submitting claims via the Portal, see the <u>Submit Claim</u> section.*

To submit institutional claims via the Portal, log in, select **Claims > Submit Claim Institutional**, and complete these three steps as described in the following sections:

- Enter provider, patient, and claim information.

- Enter diagnosis codes, other insurance (TPL), condition codes, occurrence codes, value codes, and surgical procedure information.

- Enter service details, attachments, and claim notes.

Step 1: Provider, Patient, and Claim Information

Before entering information, identify whether the claim is for an inpatient or outpatient service. The **Inpatient/Outpatient** selection determines which fields are required during later steps of the process.

Figure 8 – Submit Institutional Claim: Step 1

Provider Information Section

The *Provider Information* section displays the NPI (or Provider ID) and name of the billing provider and enables users to identify *other* providers associated with the claim.

Figure 9 – Provider Information Section (Institutional Claim)

In addition to the autofilled **Billing Provider** information, users may enter information for the other providers as follows:

- **Institutional Provider** – The NPI of the facility billing the claim; should always match the Billing Provider ID.

- **Attending Provider** – Required for inpatient, outpatient, ASC, and LTC claims. When adding an attending provider, be sure to use the NPI of the individual provider that rendered the service, not the NPI of the group to which the rendering provider may be linked. (A taxonomy for the attending provider is optional.)

- **Operating Provider** – Required if surgical codes are submitted.

- **Other Operating Provider** – Required for claims with an ordering, prescribing, or referring provider that is not identified in the other fields in this section.

Users can identify these additional providers either by typing their information directly into the fields or by clicking the magnifying glass icon to search for the provider by ID, name, or organization. When the desired provider is selected from the search results, that provider's information automatically populates the appropriate fields.

Patient Information Section

The *Patient Information* section is intended to collect information about the member for whom the claim is being submitted, and associates all the plan and benefit information to that particular member.

Figure 10 – Patient Information Section (Institutional Claim)

> Note: If the system does not find a match based on Member ID, first name, and last name, it displays the error message, "Member not found," and the claim submission process will not be able to continue until valid information is entered.

Claim Information Section

The *Claim Information* section is intended to collect information about the claim (header-level instructions).

Figure 11 – Claim Information Section (Institutional Claim)

The **Covered Dates** fields are **required for all institutional claims**. The dates entered in these fields are the dates of service for the claim and are used to verify eligibility. Every date entered on the service detail lines of the claim should be within those two dates.

> *Note: For inpatient claims that include charges for outpatient services that were provided within 3 days preceding the admission, the From date in this field should be the date of the earliest outpatient service detail on the claim.*

For the **Admission Date/Hour** fields, the date is **required for inpatient and LTC**. The hour is **required for inpatient**.

The **Admission Type** field is **required for inpatient, outpatient, and LTC**. For a list of applicable codes, see field 14 of the *UB-04* paper-claim instructions in the Table 4.

The **Admission Source** field is **required for the receiving hospital for inpatient transfers**. Admission source code 4 should be used.

The **Admitting Diagnosis** fields are **required for inpatient and LTC**. Confirm the correct ICD version is selected and enter the ICD diagnosis code provided at the time of admission, as stated by the physician.

The **Patient Status** field is required for inpatient, outpatient, LTC, home health care, and hospice. The code entered should reflect the member's discharge status as of the ending service date of the period covered on this claim. For a list of applicable codes, see the instructions for field 17 of the *UB-04* paper claim in Table 4.

The **Type of Bill** field is **required for all institutional claims**. A current list of **Type of Bill** codes is available by subscription from the NUBC website at nubc.org.

The **Patient Number** field is required for all Portal claims. The patient number is the unique identifier assigned by the provider to use internally to identify the person who received the services .

If you have other insurance information to enter, check the **Include Other Insurance** box located at the bottom of the page before clicking Continue. Use this option to create Medicare crossover claims as well as to enter TPL information on a claim.

Completing Step 1

After entering all the required information for Step 1 of the institutional claim submission process, click **Continue** to proceed to Step 2.

Step 2: E Code, Diagnosis Code, Other Insurance (TPL), Condition Codes, Occurrence Codes, and Value Codes

Before entering information for Step 2, review a summary of the provider, patient, and claim information you entered in Step 1. This summary is located at the top of the *Submit Institutional Claim: Step 2* page.

Figure 12 – Submit Institutional Claim: Step 2 – Summary Information

> Note: The sections and fields that are visible within Step 2 depend on the information entered in Step 1.

External Cause of Injury (E Code)

The **E Code Diagnosis** field is required if applicable. Use the appropriate external cause of injury (ECI) diagnosis codes (also known as E codes) provided at the time of admission, as stated by the physician. E codes indicate the external cause of injury, poisoning, or adverse effect. Up to three E codes may be entered.

For each E code, follow these steps:

1. Select the E code diagnosis type. (The default is ICD-10-CM.)
2. Enter the appropriate E code.
   – As you type, E codes and descriptions will appear in a pop-up window.
   – Select the appropriate code from the pop-up window to add it to the E Code Diagnosis field.
3. Click **Add**.

Figure 13 – External Cause of Injury

Diagnosis Codes

Add one or more diagnosis codes for the claim. Note that the first diagnosis code entered is considered the principal (primary) diagnosis code.

For each diagnosis code, follow these steps:

1. Select the diagnosis type. (The default is ICD-10-CM.)

2. Enter the appropriate diagnosis code.
   - As you type, diagnosis codes and descriptions will appear in a pop-up window.
   - Select the appropriate code from the pop-up window to add it to the Diagnosis Code field.

3. Select the appropriate present-on-admission (POA) indicator, if applicable.
   - For inpatient claims, a present-on-admission (POA) indicator is required for all diagnosis codes except those explicitly exempt from POA reporting.
   - A list of diagnosis codes that are *exempt* from POA reporting can be accessed from the [ICD-10-CM](#) page at cdc.gov.

4. Click **Add**.

Figure 14 – Diagnosis Codes Panel

To edit a diagnosis code from the list, select the number in the # column. To remove a code from the list, select **Remove** from the Action column.

Other Insurance Details

If the IHCP has information about commercial insurance coverage for the member, carrier information will automatically be displayed in the *Other Insurance Details* panel. Medicare carrier information must be added here, if applicable.

Figure 15 – Other Insurance Details

You can add, remove, or edit information in the *Other Insurance Details* panel:

- Click **Remove** to delete any nonapplicable carriers from the claim.

- Click the *hyperlinked number* in the # column to update a carrier's information.

- Click **[+] Click to add a new other insurance** to access the section where you can add new insurance information.

To add a new carrier, follow these steps:

1. Complete all required fields.

   – The carrier ID is the identification number the insurance company uses in electronic claim submission.

   > *Note: Except in the case of Medicare, if the carrier ID is unknown, the carrier's name can be re-entered in the **Carrier ID** field.*

   – When submitting Medicare or Medicare Replacement Plan crossover claims, you must always select one of the following options from the **Claim Filing Code** drop-down menu, depending on the type of claim:
      ➢ 16-Health Maintenance Organization (HMO) Medicare Risk [for Medicare Replacement Plans]
      ➢ MA-Medicare Part A
      ➢ MB-Medicare Part B

   For commercial insurance claims, select the claim filing code CI-Commercial Insurance Co.

Figure 16 – Adding Other Insurance

2. After entering all the required information, click **Add** to append this carrier to the *Other Insurance Details* panel.

Figure 17 – Adding Carriers to Other Insurance Details Panel

> *Note: The following step is for Medicare and Medicare Replacement Plan claims only; it is not applicable for commercial insurance claims. Header adjustment information is required for header-processed crossover claims.*

3. After you have added other insurance, click on the new carrier's number in the # column to add claim adjustment details, as follows

   a. Enter the required information in the *Claim Adjustment Details* panel.

   b. Click **Add.**

   c. Click **Save**.

Figure 18 – Claim Adjustment Details Panel

Condition Codes

If required for the claim, enter the applicable condition codes to identify conditions relating to this bill. For a list of condition codes used by the IHCP, see the instructions for *UB-04* form fields 18–14 in Table 4.

Enter condition codes in the Portal as follows:

1. Type the first few characters of the code or code description in the Condition Code field.

2. A list populates with several options based on your entry.

3. Choose the desired code from the options and then click **Add**.

4. Repeat these steps as needed to add any additional condition codes.

Figure 19 – Condition Codes

Occurrence Codes

If required for the claim, enter the applicable occurrence codes and dates to identify significant events relating to this bill. For a list of occurrence codes used by the IHCP, see the instructions for *UB-04* form fields 31a–34b in Table 4.

Enter occurrence code information in the Portal as follows:

1. Type the first few characters of the code or code description into the Occurrence Code field.

   A list populates with several options based on your entry.

2. Choose the desired code from the options.

3. Enter the required *from* and *to* dates for the occurrence code.

4. Click **Add**.

5. Repeat these steps as needed to add any additional occurrence codes.

Figure 20 – Occurrence Codes

Value Codes

If required for the claim, enter the value codes to identify Explanation of Medicare Benefits (EOMB) or Medicare Replacement Plan EOB information. If applicable, the following value codes must be used along with the appropriate dollar or unit amounts for each:

- A1 – Medicare deductible amount

- A2 – Medicare coinsurance or copayment amount

- 06 – Medicare blood deductible amount

- 80 – IHCP covered days

Enter value code information in the Portal as follows:

1. Type the first few characters of the code or code description into the Value Code field.

   A list populates with several options based on your entry.

2. Choose the desired code from the list.

3. Enter the appropriate amount in the Amount field.

4. Click **Add**.

5. Repeat these steps as needed to add any additional value codes.

Figure 21 – Value Codes

Completing Step 2

After entering all the information required for Step 2 of the institutional claim submission process, click **Continue** to proceed to Step 3.

Step 3: Service Details, Attachments, and Claim Notes

Before entering information for Step 3, review a summary of the information entered during Step 1 and Step 2. This summary is located at the top of the *Submit Institutional Claim: Step 3* page.

Figure 22 – Submit Institutional Claim: Step 3 – Summary Information

Service Details

The *Service Details* panel is used to enter detail-level information such as service dates, revenue code, procedure codes and modifiers, charge amount, and number and type of units. Revenue codes are required on all institutional claims; HCPCS codes are required for home health, outpatient, and ASC services.

When certain procedure codes are billed on the outpatient claim, National Drug Code (NDC) information is also required, including NDC number, quantity, and unit of measure. See *Procedure Codes That Require NDCs*, accessible from the *Code Sets* page at in.gov/medicaid/providers for a table of applicable codes.

Figure 23 – Adding a Service Detail

After you have entered all the detail information for a service, click **Add**. To add additional service details, click the plus sign (+) under the last service detail line completed. Up to 450 service lines are allowed for institutional claims.

Figure 24 – Service Details Added

#	From Date	To Date	Revenue Code	HCPCS/Procedure Code	Charge Amount	Units	Action
Service Details							
Select the row number to edit the row. Click the **Remove** link to remove the entire row.							
1	10/17/2016	10/17/2016	250-PHARMACY (ALSO SEE 063X, AN EXTENSION OF 025X) - GENERAL CLASSIFICATION		$10.00	1 Unit	Remove
2	10/17/2016	10/17/2016	307-LABORATORY - UROLOGY	81003-URINALYSIS AUTO W/O SCOPE	$20.00	1 Unit	Remove
3	10/17/2016	10/17/2016	450-EMERGENCY ROOM - GENERAL CLASSIFICATION	99284-EMERGENCY DEPT VISIT	$200.00	1 Unit	Remove
⊞ Click to add service detail.							

Other Insurance for Service Details

When submitting outpatient claims, be sure to complete the other insurance information for each of the service detail lines. The primary carrier information should have already been entered for the claim (header level) in Step 2.

To add other insurance information to a service detail, follow these steps:

1. Click the hyperlinked row number in the # column of the *Service Details* panel (Figure 24) to display the *Other Insurance for Service Detail* panel (Figure 25) for that service line.

2. Select the carrier name from the Other Carrier drop-down menu and enter information in the TPL/Medicare Paid Amount and the Paid Date fields.

3. Click **Add**.

Figure 25 – Other Insurance Information for Service Details

#	Carrier ID	TPL/Medicare Paid Amount	Paid Date	Action
Other Insurance for Service Detail				
Click the row number to edit the row. Click the **Remove** link to remove the entire row.				
⊟ Click to collapse.				

*Other Carrier [123456-Medicare ▼]

*TPL/Medicare Paid Amount [$10.00]   *Paid Date ❶ [10/17/2016 ▦]

[**Add**]   [**Cancel**]

After other insurance information has been added for a service detail, adjustment information, such as coinsurance and deductible amounts, should also be added, as described in the following steps:

1. Click the hyperlinked number for the service detail for which you want to add the adjustment.

2. In the *Other Insurance for Service Detail* panel, click the hyperlinked number in the # column to access the *Claim Adjustment Details* panel for that carrier.

3. Enter the adjustment information.

4. Click **Add** and then click **Save**.

Figure 26 – Adjustment Information for Claim Details

Attachments

The *Attachments* panel is used to upload supporting documents electronically or to indicate that you intend to mail the appropriate documentation to the IHCP.

1. In the Transmission Method drop-down menu, select **FT-File Transfer** to upload a file or **BM-By Mail** to send documents to the IHCP by mail.

Figure 27 – Attachment Transmission Methods

> *Note: If you plan to upload an attachment, be aware that the attachment file size limit is 5 MB and valid file types for upload include: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif, and .tiff.*

2. Identify the attachment being mailed uploaded:
   – If sending attachment by mail, create a unique attachment control number (ACN) and enter that number in the Control # field (see Figure 28). This number **must** match the number submitted on the *IHCP Claims Attachment Cover Sheet* (available on the *Forms* page at in.gov/medicaid/providers) that is mailed with the documentation. See the *Mailing Paper Attachments for Electronic Claims* section for details.
   – If sending the attachment using the file transfer method, click **Browse** in the Upload File field to locate the file you wish to upload (see Figure 29).

3. Select the appropriate option from the Attachment Type drop-down menu.

4. Click **Add** after selecting each individual document to attach.

Figure 28 – Attachments Panel Using By Mail Transmission Method

Figure 29 – Attachments Panel Using File Transfer Method

Claim Note Information

Although the fields in the *Claim Note Information* panel are not required, they can be used if needed to provide clarifying information about the claim, as follows:

1. Select an option from the Note Reference Code drop-down menu:
   – Additional Information
   – Allergies
   – Goals, Rehabilitation Potential, or Discharge Plans
   – Diagnosis Description
   – Durable Medical Equipment (DME) and Supplies
   – Medications
   – Nutritional Requirements
   – Orders for Disciplines and Treatments
   – Functional Limitations, Reason Homebound, or Both
   – Reasons Patient Leaves Home
   – Times and Reasons Patient Not at Home
   – Unusual Home, Social Environment, or Both
   – Safety Measures
   – Supplementary Plan of Treatment
   – Updated Information

> *Note:* *The Note Reference Code field provides a list of options to identify the functional area or purpose to which the note applies.*

2. Enter any necessary information in the Note Text field.

3. Click **Add** to add the claim note.

Figure 30 – Claim Note Information Panel

Claim Note Information			
Click the **Remove** link to remove the entire row.			
#	Note Reference Code	Note Text	Action
🗆 Click to collapse.			

Note Reference Code [▾]

Note Text [   ]

[Add]   [Cancel]

See the *Claim Notes* section for more information about using claim notes.

Submit for Final Preview

After you have provided all the information for the claim, and added attachments and claim notes as needed, click **Submit** to proceed to the final preview, from which you can modify or submit the claim.

Confirm Claim

The Portal displays the claim information for review before you confirm your submission.

Figure 31 – Confirm Institutional Claim

1. Review the information and then select the appropriate option from the bottom of the page:
   - If you discover that you need to edit the claim information, use the **Back to Step** buttons to navigate to the appropriate step and edit the desired information.
   - Click **Print Preview** to print a copy of the claim information being submitted.
   - Click **Cancel** if you decide not to submit the claim. When you choose to cancel the claim submission, data entered during the process will be lost and the claim data will not be submitted.
   - If, after reviewing the information, you are ready to submit the claim, click **Confirm**.

2. After you click **Confirm** to submit the claim for processing, the Portal displays the Claim ID and current claim status.

> *Note: Use the Claim ID as the reference to check the status of your claim or any time you reference this claim in an inquiry.*

Figure 32 – Institutional Claim Submission Confirmation

3. You will also see a few options at the bottom of page:
   - The **Print Preview** button allows you to view and print a copy of your claim receipt.
   - The **Copy** button allows you to select member or claim data to paste into a new claim submission.
   - The **New** button allows you to start a new institutional claim.

Section 3: Professional Claim Billing Instructions

This section provides information about submitting professional claims using the *CMS-1500 Health Insurance Claim Form* (*CMS-1500* claim form) or its *Health Insurance Portability and Accountability Act* (HIPAA)-compliant electronic equivalents: the *837 Health Care Claim: Professional* (837P) transaction and the Provider Healthcare Portal (Portal) professional claim.

The instructions for completing the *CMS-1500* paper claim form align with the electronic claim requirements mandated by the HIPAA Administrative Simplification requirements.

Types of Services Billed on Professional Claims

Table 5 shows the types of services that specific provider types or specialties can bill on the *CMS-1500* claim form, the Portal professional claim, or the 837P electronic transaction.

Table 5 – Types of Services Billed on Professional Claims

Provider Type or Specialty	Type of Services
Addiction Services (Type 35, specialties 835 and 836) *Note: These specialties were moved to provider type 11, effective November 1, 2020.*	Opioid treatment program (OTP) services Substance use disorder (SUD) residential addiction treatment facility services
Advanced practice registered nurse (APRN) (Type 09, specialties 090–093 and 095)	Midwife services Nurse practitioner services Nurse anesthetist services Clinical nurse specialist services
Applied behavior analysis (ABA) therapist (Type 11, specialty 615)	ABA therapy*
Audiologist (Type 20)	Audiology services*
Certified registered nurse anesthetist (CRNA) (Type 09, specialty 094)	Nurse anesthetist services*
Chiropractor (Type 15)	Chiropractic services*
Clinic (Type 08, specialties 081–084 and 087)	Family planning services Federally qualified health center (FQHC) services Medical services Nurse practitioner services Rural health clinic (RHC) services Therapy services Surgical services
Comprehensive outpatient rehabilitation facility (CORF) (Type 04, specialty 041)	Outpatient rehabilitation
Dentist (Type 27)	Oral surgery (using Current Procedural Terminology [CPT] or Healthcare Common Procedure Coding System [HCPCS] codes)
Durable medical equipment (DME) and home medical equipment (HME) dealer (Type 25)	DME, HME, and medical supplies*

Provider Type or Specialty	Type of Services
Genetic counselor (Type 36)	Genetic counseling
Hearing aid dealer (Type 22)	Hearing aids*
Independent diagnostic testing facility (Type 28, specialties 282 and 283)	Laboratory services – Diagnostic testing only
Laboratory (Type 28, specialties 280 and 281)	Laboratory services
Medical Review Team (MRT) Copy Center (Type 34)	Copying and provision of medical records for the MRT program*
Mental health provider (Type 11, specialties 110, 111, 114, 115, 611, 612, and 613) *Note: Effective November 1, 2020, the name of provider type 11 was changed to Behavioral Health Provider, and additional specialties were added.*	Outpatient mental health and substance use disorder (SUD) treatment services Medicaid Rehabilitation Option (MRO) services
Midlevel practitioner billing under the supervising physician's rendering National Provider Identifier (NPI)	Services provided by a midlevel practitioner
Optician (Type 19)	Optical services*
Optometrist (Type 18)	Optometric services*
Pharmacy (Type 24)	Supplies
Physician – Doctor of medicine (MD) and doctor of osteopathy (DO) (Type 31)	Anesthesia services Laboratory services Medical services – Professional component Mental health services Radiology services Renal dialysis services Surgical services Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
Physician assistant (Type 10)	Physician assistant services
Podiatrist (Type 14)	Podiatry services*
Public health agency (Type 13)	Medical services
Psychiatric residential treatment facility (PRTF) (Type 03, specialty 034)	Behavioral health residential treatment
Radiology facility/x-ray clinic (Type 29)	Radiological services
School corporation (Type 12)	Therapy services – physical, occupational, speech, and mental health Audiology services Nursing services provided by a registered nurse IEP-required special transportation services on dates of another covered IEP service
Therapist (Type 17)	Therapy services – Physical, occupational, and speech/language

Provider Type or Specialty	Type of Services
Transportation provider (Type 26)	Transportation services, including hospital-based ambulance services*
Waiver provider (Type 32)	Home and community-based services (HCBS) waiver services
*Note: An asterisk indicates that the provider type or specialty is limited to a specific set of procedure codes (or code set) for IHCP reimbursement. See the Code Sets page at in.gov/medicaid/providers.	

Using Modifiers on Professional Claims

The IHCP accepts up to four modifiers per procedure code submitted on a professional claim, including paper *CMS-1500* claim forms, 837P transactions, and professional claims submitted through the Portal. For a list of modifiers used on the *CMS-1500* claim form or electronic equivalent, see *Procedure Code Modifiers for Professional Claims*, accessible from the Code Sets page at in.gov/medicaid/providers.

A U modifier indicates that a procedure was altered by circumstance, but not changed in meaning. Modifiers U1 through U9 and UA through UD are defined as "Medicaid Level of Care 1–13, as defined by each state." The IHCP uses many of these modifiers for dual purposes.

Waiver providers must use the U7 modifier for all waiver services. Providers should use modifier U7 even if other modifiers are required in the procedure code and modifier combination. Failure to add the U7 modifier and any other required modifier may result in claim denial or an incorrect payment. Claims for waiver services are currently exempt from National Correct Coding Initiative (NCCI) editing.

Billing Guidance for Dates of Service

Providers must provide the *from* and *to* dates, even if the service was for one single date of service. All services performed or delivered within the same calendar month and in a consecutive-day pattern must be billed with the appropriate units of service and *from* and *to* period. Failure to report the correct date span and the number of units performed during the date span could result in a claim denial. The following example shows the proper use of span dates to avoid unnecessary Medically Unlikely Edits (MUE)-related denials. When similar services are rendered to the same member at multiple service locations on a single date of service, it is acceptable to bill the total units on a single line item using a single place of service (POS). Documentation in the medical record must contain the most specific POS for each service rendered.

> *Example:* A community mental health center (CMHC) provides four units of case management services to a member in the office at 10 a.m. on July 10, 2019, and on the same day provides an additional three units of case management at 3 p.m. in the member's home. The CMHC may bill for seven units of service on one detail of the claim at POS 11 (office) and document in the medical record the number of units rendered at each individual POS.

Managed care entities (MCEs) may have other specific reimbursement guidelines. Providers rendering services in the managed care delivery system should contact the MCE with which they are contracted for information about billing multiple service locations.

National Provider Identifiers for Professional Claims

NPIs are required on the professional claim for all applicable providers:

- The NPI of the **billing** or **group** provider must be entered in field 33a of the *CMS-1500* or corresponding field on the 837P electronic transaction. On the Portal, the billing or group NPI is automatically entered on the claim based on the Provider account being used.

  > *Note:* *It is imperative that providers enter the NPI of the billing or group provider **only** in field 33a on the CMS-1500 claim form. Placement of more than one NPI in this field could result in reimbursement of the claim to the wrong provider. If the IHCP makes a payment to the wrong provider, the provider must refund the incorrect payment. Mail refunds to the following IHCP address:*
  >
  > **DXC Refunds**
  > **P.O. Box 1937, Dept. 104**
  > **Indianapolis, IN 46206-1937**

- The NPI of the **rendering** provider is entered for each service detail of the claim – field 24J of the *CMS-1500* or corresponding field on the 837P or Portal professional claim detail. The Portal and 837P also allow providers to enter a rendering provider NPI at the claim header level.

- The NPI of the **ordering, prescribing, or referring** provider, if applicable, is entered in field 17b of the *CMS-1500* or equivalent field on the 837P or Portal professional claim.

Atypical providers (nonmedical service providers) use their IHCP Provider ID in place of an NPI.

See Table 6 for specific instructions on entering NPIs or Provider IDs on the *CMS-1500* claim form. See the *Provider Enrollment* module for information about the four provider classifications: billing; group; rendering; and ordering, prescribing, or referring (OPR). For more information about NPI requirements, see the *National Provider Identifier and One-to-One Match* section of this module.

Guidelines for Completing the *CMS-1500* Claim Form

> *Note:* *The instructions provided in this section apply to the IHCP guidelines only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC official instruction manual can be accessed at the NUCC website at nucc.org.*

This section provides a brief overview of the instructions for completing the *CMS-1500* claim form. Noncompliant *CMS-1500* paper claims are returned to the provider.

> *Note:* *Providers are required to use the standard red-ink form for paper submission. Claims submitted on black-and-white copies of the CMS-1500 claim form will be returned, and providers will have to resubmit the claim on the official red claim form.*

CMS-1500 Claim Form – Field-by-Field Instructions

Table 6 provides information about the fields (or *data elements*) on the *CMS-1500* claim form. Some fields are required, and others are optional. *Required* or *required, if applicable* fields are indicated by **bold** type. *Optional* and *Not applicable* fields are displayed in normal type. Specific instructions applicable to a particular provider type are included, where necessary.

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The IHCP accepts only the revised version of the *CMS-1500 (02/12)* paper claim form. Paper claims submitted on previous versions of the *CMS-1500* will not be processed and will be returned to the provider. Figure 33 shows a sample copy of the *CMS-1500, Version 02/12* claim form.

<div align="center">Table 6 – CMS-1500, Version 02/12, Claim Form Fields</div>

Form Field	Narrative Description/Explanation
1	**[INSURANCE CARRIER SELECTION]** – Enter **X** in the box for Medicaid. **Required.**
1a	**INSURED'S I.D. NUMBER** (For Program in Item 1) – Enter the IHCP Member ID (also known as RID). Must be 12 digits. **Required.**
2	**PATIENT'S NAME** (Last Name, First Name, Middle Initial) – Provide the member's last name, first name, and middle initial obtained from the Interactive Voice Response (IVR) system, electronic claim submission (ECS), or Portal verification. **Required.**
3	PATIENT'S BIRTH DATE – Enter the member's birth date in MMDDYY format. Optional. SEX – Enter **X** in the appropriate box. Optional.
4	INSURED'S NAME (Last Name, First Name, Middle Initial) – Not applicable.
5	PATIENT'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE (Include Area Code) – Enter the member's complete address information. Optional.
6	PATIENT RELATIONSHIP TO INSURED – Not applicable.
7	INSURED'S ADDRESS (No., Street), CITY, STATE, ZIP CODE, TELEPHONE (Include Area Code) – Not applicable.
8	RESERVED FOR NUCC USE – Not applicable.
9	**OTHER INSURED'S NAME** (Last Name, First Name, Middle Initial) – If other insurance is available, and the policyholder is other than the member shown in fields 1a and 2, enter the policyholder's name. **Required, if applicable.**
9a	**OTHER INSURED'S POLICY OR GROUP NUMBER** – If other insurance is available, and the policyholder is other than the member noted in fields 1a and 2, enter the policyholder's policy and group number. **Required, if applicable.**
9b	RESERVED FOR NUCC USE – Not applicable.
9c	RESERVED FOR NUCC USE – Not applicable.
9d	**INSURANCE PLAN NAME OR PROGRAM NAME** – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, enter the policyholder's insurance plan name or program name. **Required, if applicable.**
The information in fields 10a–10c is needed for follow-up third-party recovery actions.	
10a	**IS PATIENT'S CONDITION RELATED TO** – **EMPLOYMENT** (Current or Previous) – Enter **X** in the appropriate box. **Required, if applicable.**
10b	**IS PATIENT'S CONDITION RELATED TO** – **AUTO ACCIDENT** – Enter **X** in the appropriate box. **Required, if applicable.** **PLACE** (State) – Enter the two-character state code. **Required, if applicable.**
10c	**IS PATIENT'S CONDITION RELATED TO** – **OTHER ACCIDENT** – Enter **X** in the appropriate box. **Required, if applicable.**
10d	CLAIM CODES (Designated by NUCC) – The claim codes identify additional information about the patient's condition on the claim. When reporting more than one code, enter three blank spaces and then the next code. This field allows for the entry of 19 characters. Optional.
Fields 11 and 11a through 11d are used to enter member insurance information.	
11	**INSURED'S POLICY GROUP OR FECA NUMBER** – Enter the member's policy and group number of the other insurance. **Required, if applicable.**

Form Field	Narrative Description/Explanation
11a	**INSURED'S DATE OF BIRTH** – Enter the member's birth date in MMDDYY format. **Required, if applicable.** **SEX** – Enter an **X** in the appropriate sex box. **Required, if applicable.**
11b	OTHER CLAIM ID (Designated by NUCC) – Enter additional information about another claim payer source. This field allows for the entry of two characters to the left of the vertical, dotted line and 28 characters to the right of the dotted line. Optional.
11c	**INSURANCE PLAN NAME OR PROGRAM NAME** – Enter the member's insurance plan name or program name. **Required, if applicable.**
11d	**IS THERE ANOTHER HEALTH BENEFIT PLAN?** – Enter **X** in the appropriate box. If the response is *Yes*, complete fields 9, 9a, and 9d. **Required, if applicable.**
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – Not applicable.
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – Not applicable.
14	**DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)** – For illness, enter the date of the first symptom. For injury, enter the accident date. For pregnancy-related services, enter the date of the last menstrual period (LMP). Enter the date in MMDDYY format. **Required, if applicable.** **QUAL** – Enter the applicable three-character qualifier code. **Required, if applicable.**
15	OTHER DATE – Enter date in MMDDYY format. Optional. QUAL – The qualifier code is not applicable.
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION – FROM/TO –** If field 10a is *Yes*, enter the applicable *from* and *to* dates in a MMDDYY format. **Required, if applicable.**
17	**NAME OF REFERRING PROVIDER OR OTHER SOURCE** – Enter the name of the referring physician. For waiver-related services, enter the referring provider or the case manager name. **Required, if applicable.** Qualifier code is not applicable. *Note: The term "referring provider" includes physicians primarily responsible for the authorization of treatment for Right Choices Program members.*
17a	**[ID NUMBER OF REFERRING PROVIDER, ORDERING PROVIDER, OR OTHER SOURCE]** – Enter the qualifier in the first box of 17a, indicating what the number reported in the second box (shaded) of 17a represents. Atypical providers should report the IHCP Provider ID in the second box of 17a. Healthcare providers should report the taxonomy code in the second box of 17a. A qualifier is required when entering the IHCP Provider ID or taxonomy. Qualifiers to report to IHCP: • **G2** is the qualifier that applies to the IHCP Provider ID for the atypical (nonhealthcare) provider. The Provider ID includes nine numeric characters and one alpha character for the service location. • **ZZ** and **PXC** are the qualifiers that apply to the provider taxonomy code. The taxonomy code includes 10 alphanumeric characters. Taxonomy may be needed to establish a one-to-one NPI/Provider ID match if the provider has multiple locations. **Required when applicable and for any waiver-related services.**
17b	**NPI** – Enter the 10-digit numeric NPI of the referring provider, ordering provider, or other source. **Required, if applicable.**
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – FROM/TO** – Enter the requested *from* and *to* dates in MMDDYY format. **Required, if applicable.**
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC) – This field is being used as a notes section for information, such as partial sterilization or third-party liability (TPL) 90-day no response. This field is limited to 80 characters. The additional claim information is the functional equivalent of the claim note section on the 837P and Portal claim submissions. Optional.

Form Field	Narrative Description/Explanation
20	OUTSIDE LAB? – Not applicable. CHARGES – Not applicable.
21A–L	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** – Enter the ICD diagnosis codes in priority order. A total of 12 codes can be entered. **Required.** **ICD Ind.** – Enter **0** to indicate that the diagnosis codes in fields 21A–L are ICD-10 diagnosis codes. **Required.**
22	**RESUBMISSION CODE, ORIGINAL REF. NO.** – Applicable for Medicare Part B crossover claims and Medicare Replacement Plan crossover claims. For crossover claims, the combined total of the Medicare coinsurance or copayment and deductible must be reported on the left side of field 22, under the heading *Code*. The Medicare paid amount (actual dollars received from Medicare or the Medicare Replacement Plan) must be submitted in field 22, on the right side under the heading *Original Ref. No*. **Required, if applicable.** <table><tr><td>*Note:*</td><td>*When submitting a crossover claim on the CMS-1500 paper claim form, providers must complete the* IHCP Third-Party Liability (TPL)/Medicare Special Attachment Form *and submit with the claim. This form should include Medicare payments and itemized coinsurance, copayment, and deductibles applied at the detail level. The form and instructions for completing it are available on the* Forms *page at in.gov/medicaid/providers.*</td></tr></table>
23	PRIOR AUTHORIZATION NUMBER – The prior authorization (PA) number is not required, but entry is recommended when applicable to assist in tracking services that require PA. Optional.
A maximum of six detail lines (lines 1–6 in fields 24A–24J) are allowed per CMS-1500 paper claim form.	

24A to 24H
Top Half – Shaded Area
	NATIONAL DRUG CODE INFORMATION – The shaded portion of lines 1-6 in fields 24A to 24H is used to report national drug code (NDC) information for applicable procedure codes (reported in the bottom half of field 24D). **Required, if applicable.**
	
	To report this information, begin at the far left, in the top (shaded) half of the appropriate row as follows:
	
	1. Enter the NDC qualifier of N4.
	2. Enter the 11-digit numeric NDC code in the "5-4-2" format. Do not include spaces or hyphens.
	3. Enter the drug description.
	4. Enter the NDC unit-of-measure qualifier:
	    – F2 – International Unit
	    – GR – Gram
	    – ME – Milligram
	    – ML – Milliliter
	    – UN – Unit
	5. Enter the NDC quantity (administered amount) in the format 9999.999.

24A Bottom Half	**DATE(S) OF SERVICE** – **From/To** – Provide the *from* and *to* dates, in MMDDYY format, for each service listed in lines 1-6. **Required.** <table><tr><td>*Note:*</td><td>*Date of service is the date the specific services were actually supplied, administered, dispensed, or rendered to the patient.* *For services requiring PA, the "from" date of service cannot be prior to the dates for which the service was authorized. The "to" date of service cannot exceed the dates for which the service was authorized.*</td></tr></table>

Form Field	Narrative Description/Explanation
24B Bottom Half	**PLACE OF SERVICE** – Enter the place of service (POS) code for the facility where each service was rendered. **Required.** *Note: For a list of POS codes, go to the [Place of Service Code Set](#) page on the CMS website at cms.hhs.gov.*
24C Bottom Half	**EMG** – Enter an emergency indicator of Y in this field to indicate services (CPT or HCPCS codes in field 24D, lines 1–6) that were for emergency care. Enter **Y** or **N**. **Required.**
24D Bottom Half	**PROCEDURES, SERVICES, OR SUPPLIES** **CPT/HCPCS** – Enter the appropriate procedure code for the service rendered. Enter only one procedure code on each detail line. **Required.** **MODIFIER** – Enter the appropriate modifier, if applicable. Up to four modifiers are allowed for each procedure code. **Required, if applicable.**
24E Bottom Half	**DIAGNOSIS POINTER –** For each procedure code in field 24D, lines 1-6, enter the letter (A–L) corresponding to the applicable diagnosis codes in field 21. A minimum of one and a maximum of four diagnosis code pointers can be entered for each line. **Required.** *Note: The alpha value of A–L entered for the diagnosis pointer will be systematically converted to match the electronic data interchange (EDI) value of 1–12 as depicted as follows:* | A	B	C	D	E	F	G	H	I	J	K	L
---	---	---	---	---	---	---	---	---	---	---	---
1_	2_	3_	4_	5_	6_	7_	8_	9_	10	11	12	
24F Bottom Half	**$ CHARGES** – Enter the total amount charged for the procedure performed, based on the number of units indicated in field 24G. The charged amount is the sum of the total units multiplied by the single unit charge. Each line is computed independently. This is a 10-digit field. **Required.**
24G Bottom Half	**DAYS OR UNITS** – Enter the number of units being claimed for each procedure code. Six digits are allowed, and 9999.99 units is the maximum that can be submitted. **Required.**
24H	**EPSDT Family Plan** – Use this field to indicate the following circumstances, for each applicable line: • Report Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services by entering the appropriate NUCC two-character code in the shaded, top half of the field. • Report family planning services by entering a **Y** (for yes) in the unshaded, bottom half of the field. • If the patient is pregnant, indicate with a **P** in the unshaded, bottom half of the field. **Required, if applicable.**
24I Top Half – Shaded Area	**ID. QUAL –** Enter the qualifier indicating what the rendering provider number reported in the shaded area of 24J represents. **Required, if applicable.** • **G2** is the qualifier that applies to the IHCP Provider ID for atypical, nonhealthcare providers. • **ZZ** and **PXC** are the qualifiers that apply to the provider taxonomy code.
24J Top Half – Shaded Area	**RENDERING PROVIDER ID. #** – Enter the IHCP Provider ID or taxonomy code of the provider that rendered the service. **Required, if applicable.** • **Provider ID** – Atypical providers (for example, certain transportation and waiver service providers) are required to submit their IHCP Provider ID. If billing for case management, the case manager's Provider ID must be entered here. (Provider ID is indicated by qualifier G2 in field 24I.) • **Taxonomy** – The taxonomy code includes 10 alphanumeric characters. The taxonomy code is optional unless required for a one-to-one match. (Taxonomy is indicated by qualifier ZZ or PXC in field 24I.)
24J Bottom Half	**RENDERING PROVIDER ID. # – NPI** – Enter the NPI of the provider that rendered the service. **Required, if applicable.**

Form Field	Narrative Description/Explanation
25	FEDERAL TAX I.D. NUMBER – Not applicable.
26	PATIENT'S ACCOUNT NO. – Enter the internal patient tracking number. Optional.
27	ACCEPT ASSIGNMENT? – The *IHCP Provider Agreement* includes details about accepting payment for services. Optional.
28	**TOTAL CHARGE** – Enter the total of all detail line charges in column 24F. This is a 10-digit field, such as 99999999.99. **Required.**
29	**AMOUNT PAID** – Enter the total payment received from all other sources, excluding the Medicare or Medicare Replacement Plan paid amount (which is entered in field 22). Combine all applicable items and enter the total this field. This is a 10-digit field. **Required, if applicable.** If another insurer was billed but paid zero, enter **0** in this field. > *Note: If another insurer made a payment on the claim (including payments of zero), providers submitting the claim to the IHCP on a CMS-1500 paper claim form must complete and submit the [IHCP TPL/Medicare Special Attachment Form](#) with the claim. The form should include all prior payments made at the detail level. The form and instructions for completing it are available on the [Forms](#) page at in.gov/medicaid/providers.* > > *For documentation requirements related to IHCP claims when the primary carrier denied the claim or paid at zero, see the [Documenting Denied or Zero-Paid Claims](#) section.*
30	RSVD FOR NUCC USE – Not applicable.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS – IHCP participating providers must have a signature on file; therefore, this field is optional. DATE – Enter the date the claim was filed. Optional.
32	SERVICE FACILITY LOCATION INFORMATION – Enter the facility name and address where the services were rendered, if other than a private home or the service location on file. This field is optional, but it helps DXC contact the facility, if necessary. Optional.
32a	SERVICE FACILITY LOCATION – NPI – Not applicable.
32b	SERVICE FACILITY LOCATION [QUALIFIER AND ID NUMBER] – Not applicable.
33	**BILLING PROVIDER INFO & PH #** – Enter the *service location* name and address (including ZIP Code+4) as listed on the provider enrollment profile for the billing or group provider. The address in this field should match the *service location* (practice site) address (not the home office [legal], pay-to, or mail-to address) on file for the billing or group provider. **Required.** > *Note: If the U.S. Postal Service provides an expanded ZIP Code (ZIP Code+4) for a geographic area, this expanded ZIP Code must be entered on the claim form.*
33a	**BILLING PROVIDER – NPI** – Enter the billing or group provider NPI. **Required.** Atypical providers should follow instructions in 33b.
33b	**BILLING PROVIDER – [QUALIFIER AND ID NUMBER] –** If the billing provider is an atypical provider, enter the qualifier G2 and the billing provider's IHCP Provider ID. Healthcare providers may enter a qualifier of ZZ or PXC and the billing provider taxonomy code. Taxonomy may be needed to establish a one-to-one NPI/Provider ID match if the provider has multiple locations. **Required, if applicable.**

Figure 33 – *CMS-1500* Claim Form

Guidelines for Completing Professional Claims Electronically

The IHCP accepts professional claims submitted electronically through an 837P transaction or via the Portal.

As with the *CMS-1500* paper claim form, the IHCP recognizes up to 12 ICD diagnosis codes on the 837P electronic transmission or Portal professional claim. *Core*MMIS processes a maximum of 50 detail lines on the 837P or Portal professional claim; whereas only six detail lines are allowed per paper *CMS-1500* claim form.

The following section provides a step-by-step example of the Portal claim-submission process for a professional claim.

For information about completing the 837P electronic transaction, see the following resources:

- *Electronic Data Interchange* module

- *837P Implementation Guide* (available for purchase and download through the Washington Publishing Company website at wpc-edi.com)

- 837P Companion Guide, available from the *IHCP Companion Guides* page at in.gov/medicaid/providers

For general information about electronic billing, see the *Electronic Claims* section of this module.

Portal Professional Claim Submission Process

> *Note: For general information about submitting claims via the Portal, see the Submit Claim section.*

To submit professional claims via the Portal, log in, select **Claims > Submit Claim Professional**, and complete these three steps as described in the following sections:

- Enter provider, patient, and claim information.

- Enter diagnosis codes and other insurance (TPL).

- Enter service details, attachments and claim notes.

Step 1: Provider, Patient, and Claim Information

Figure 34 – Submit Professional Claim: Step 1

Provider Information Section

The *Provider Information* section displays the billing provider's NPI or Provider ID and name, and allows users to identify the following additional providers:

- Rendering Provider – Required. The taxonomy code for the rendering provider is optional unless required for a one-to-one match.

- Referring Provider – Required if applicable.

- Service Facility Location – Optional. If services were rendered at a facility other than a private home or the service location on file for the provider, the claim processor can use the information in this field to contact the facility, if necessary.

Figure 35 – Provider Information Section (Professional Claim)

Users can identify these additional providers either by typing their information directly into the fields or by clicking the magnifying glass icon to search for the provider by ID, name, or organization. When the desired provider is selected from the search results, that provider's information automatically populates the appropriate fields.

Patient Information Section

The *Patient Information* section is intended to collect information about the member for whom the claim is being submitted, and associates all the plan and benefit information to that particular member.

Figure 36 – Patient Information Section (Professional Claim)

> Note: If the system does not find a match based on Member ID, first name, and last name, it displays the error message, "Member not found," and the claim submission process will not be able to continue until valid information is entered.

Claim Information Section

The *Claim Information* section is intended to collect information about the claim (header-level instructions).

Figure 37 – Claim Information Section (Professional Claim)

The **Hospital From Date** and **Hospital To Date** fields are the dates of service for the claim. The system will automatically enter a date range in these two fields that encompasses every date entered in the service detail lines of the claim.

For the **Date Type** and **Date of Current** fields:

- To indicate pregnancy, select *Pregnancy* as the date type and enter the date of the last menstrual period (LMP).

- For illness, select *Illness* as the date type and enter the date of the first symptom onset.

- For injury, select *Injury* and enter the date the injury occurred. For pregnancy-related services, enter the date of the last menstrual period (LMP)

The **Patient Number** field is required for all Portal claims. The patient number is the unique number assigned by the provider to use internally to identify the person who received the services.

If you have other insurance information to enter, check the **Include Other Insurance** box located at the bottom of the page before clicking Continue. Use this option to create Medicare crossover claims as well as to enter TPL information on a claim.

Completing Step 1

After entering all the required information for Step 1, click **Continue** to proceed to Step 2.

Step 2: Diagnosis Codes and Other Insurance (TPL)

Before entering information for Step 2, review a summary of the provider, patient, and claim information you entered in Step 1. This summary is located at the top of the *Submit Professional Claim: Step 2* page.

Figure 38 – Submit Professional Claim: Step 2 –Summary Information

Submit Professional Claim: Step 2			?
* Indicates a required field.			
Provider Information			
Billing Provider ID 1001001001	ID Type NPI	Name Dr. XXX XXX	
Patient and Claim Information			
Member ID 100100100100			
Member XXX XXX	Gender Female		
Birth Date 01/18/ XXXX	Total Charged Amount $0.00		
		Expand All | Collapse All	

> *Note: The sections and fields that are visible within Step 2 depend on the information entered in Step 1.*

Diagnosis Codes

Add one or more diagnosis codes for the claim. Up to 12 diagnosis codes lines are allowed for professional claims. Note that the first diagnosis code entered is considered the primary diagnosis code. For each diagnosis code, follow these steps:

1. Select the diagnosis type. (The default is ICD-10-CM.)

2. Enter the appropriate diagnosis code. As you type, diagnosis codes and descriptions will appear in a pop-up window. Select the appropriate code from the pop-up window to add it to the Diagnosis Code field.

3. Click **Add** to add the diagnosis code to the claim.

Figure 39 – Diagnosis Codes Panel

Diagnosis Codes			−
Select the row number to edit the row. Click the **Remove** link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.			
#	**Diagnosis Type**	**Diagnosis Code**	**Action**
1	ICD-10-CM	F102-ALCOHOL DEPENDENCE	Remove
2			
2	*Diagnosis Type ICD-10-CM ▾	*Diagnosis Code 🛈	
	Add **Reset**		

To edit a diagnosis code from the list, select the number in the # column. To remove a code from the list, select **Remove** from the Action column.

Other Insurance Details

If the IHCP has information about commercial insurance coverage for the member, carrier information will automatically be displayed in the *Other Insurance Details* panel. Medicare carrier information must be added here, if applicable.

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Figure 40 – Other Insurance Details Panel

You can add, remove, or edit information in the *Other Insurance Details* panel:

- Click **Remove** to delete any nonapplicable carriers from the claim.

- Click the number in the # column to update a carrier's information.

- Click **[+] Click to add a new other insurance** to access the section where you can add new insurance information.

See the *Other Insurance Details* section of the institutional claim example for details about entering TPL or Medicare information. The process for professional claims is similar to the process for institutional claims.

Completing Step 2

After entering all the information required for Step 2 of the professional claim submission process, click **Continue** to proceed to Step 3.

Step 3: Service Details and Attachments

Before entering information for Step 3, review a summary of the information entered during Step 1 and Step 2. This summary is located at the top of the *Submit Professional Claim: Step 3* page.

Figure 41 – Submit Professional Claim: Step 3 – Review Summary Information

Service Details

The *Service Details* panel is used to enter detail-level information such as service date, place of service code, procedure code, modifiers, diagnosis pointer, number of units, and unit type. If the claim is for an emergency service, the EMG checkbox must be selected.

When certain procedure codes are billed, National Drug Code (NDC) information is also required, including NDC number, quantity, and unit of measure. See *Procedure Codes That Require NDCs*, accessible from the *Code Sets* page at in.gov/medicaid/providers for a table of applicable codes. To add NDC information for a service detail, click [+] to expand the *NDC for Service Details* panel, and enter the NDC information for the drug administered.

The Portal allows one note per service detail on professional claims. To add a note to a service detail, click [+] to expand the *Note for Service Detail* panel, select the applicable note reference code, and then write the note in the Note Text field.

After you have entered all the detail information for a service, click **Add**. Up to 50 service lines are allowed for professional claims.

Figure 42 – Adding a Service Detail

Other Insurance for Service Detail

When a professional claim has been submitted and processed by Medicare or another third-party payer, the *Other Insurance for Service Detail* (Figure 43) section is required. TPL information, including the amount paid by the other carrier, must be entered for every procedure code. When applicable, the *Claim Adjustment Details* section must also be completed, including the applicable reason code (see Figure 44).

To add other insurance information to each service line, follow these steps:

1. Click the hyperlinked number for each service line in the *Service Details* panel, and you will be prompted to provide the Other Insurance for Service Detail information.

Figure 43 – Other Insurance for Service Detail

2. Select the carrier name from the Other Carrier drop-down menu and enter information in the TPL/Medicare Paid Amount and the Paid Date fields.

3. Click Add.

4. After you have saved the other insurance detail information for the service line, you can add the adjustment. This adjustment is where amounts such as coinsurance and deductible are entered. Click the hyperlinked number of the service detail for which you want to add the adjustment.

5. In the *Other Insurance for Service Detail* panel, click the hyperlinked number in the # column to access the *Claim Adjustment Details* panel for that carrier.

Figure 44 – Adjustment Information for Claim Details

6. Enter the adjustment information and click Add.

7. Click **Save**.

Attachments

The *Attachments* panel is used to upload supporting documents electronically or to indicate that you intend to mail the appropriate documentation to the IHCP.

1. In the Transmission Method drop-down menu, select **FT–File Transfer** to upload a file or **BM–By Mail** to indicate that documents will be sent to the IHCP by mail.

Figure 45 – Attachment Transmission Methods

> *Note:　If you plan to upload an attachment, be aware that the attachment file size limit is 5 MB and valid file types for upload include: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif, and .tiff.*

2. Identify the attachment being mailed or uploaded:

   – If sending attachment by mail, create a unique attachment control number (ACN) and enter that number in the Control # field (see Figure 46). This number **must** match the number submitted on the *IHCP Claims Attachment Cover Sheet* (available on the *Forms* page at in.gov/medicaid/providers) that is mailed with the documentation. See the *Mailing Paper Attachments for Electronic Claims* section for details.

   – If sending the attachment using the file transfer method, click **Browse** in the Upload File field to locate the file you wish to upload (see Figure 47).

Figure 46 – Attachments Panel Using By Mail Transmission Method

Attachments					⊟
Click the **Remove** link to remove the entire row.					
#	Transmission Method	File	Control #	Attachment Type	Action
⊟ Click to collapse.					

*Transmission Method　BM-By Mail ▼
*Control #　123456789
*Attachment Type　05-Treatment Diagnosis　▼

Add　**Cancel**

Figure 47 – Attachments Panel Using File Transfer Method

Attachments					⊟
Click the **Remove** link to remove the entire row.					
#	Transmission Method	File	Control #	Attachment Type	Action
⊟ Click to collapse.					

*Transmission Method　FT-File Transfer ▼
*Upload File　　　　　　　　　　　　　　Browse...
*Attachment Type　　　　　　　　　▼

Add　**Cancel**

3. Select the appropriate option from the Attachment Type drop-down menu.

4. Click Add after selecting each individual document to attach.

Claim Note Information

Although the fields in the *Claim Note Information* panel are not required, they can be used if needed to provide clarifying information about the claim, as follows:

1. Select an option from the Note Reference Code drop-down menu:
   – Additional Information
   – Certification Narrative
   – Goals, Rehabilitation Potential, or Discharge Plans
   – Diagnosis Description
   – Third Party Organization Notes

   > Note:　The Note Reference Code field provides a list of options to identify the functional area or purpose to which the note applies. The note reference code will not impact processing.

2. Enter any necessary information in the Note Text field.

3. Click **Add** to add the claim note.

Figure 48 – Claim Note Information Panel

Claim Note Information			⊟
Click the **Remove** link to remove the entire row.			
#	Note Reference Code	Note Text	Action
⊟ Click to collapse.			

Note Reference Code　　　　　　　　▼
Note Text

Add　**Cancel**

See the *Claim Notes* section for more information about using claim notes.

Submit for Final Preview

After you have provided all the information for the claim, click **Submit** to proceed to the final preview, from which you can modify or submit the claim.

Confirm Claim

The Portal displays the claim information for review before you confirm your submission.

Figure 49 – Confirm Professional Claim

Review the information and then select the appropriate option from the bottom of the page:

– If you discover that you need to edit the claim information, use the **Back to Step** buttons to navigate to the appropriate step and edit the desired information.

– Click **Print Preview** to print a copy of the claim information being submitted.

– Click **Cancel** if you decide not to submit the claim. When you choose to cancel the claim submission, data entered during the process will be lost and the claim data will not be submitted.

– If, after reviewing the information, you are ready to submit the claim, click **Confirm**.

4. After you click **Confirm** to submit the claim for processing, the Portal displays the Claim ID and current claim status.

> *Note:* *Use the Claim ID as the reference to check the status of your claim or any time you reference this claim in an inquiry.*

Figure 50 – Professional Claim Submission Confirmation
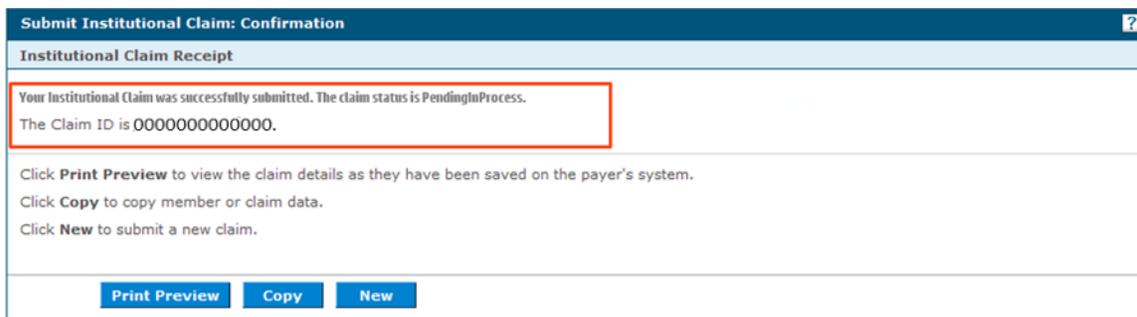
5. You will also see a few options at the bottom of page:

– The **Print Preview** button allows you to view and print a copy of your claim receipt.

– The **Copy** button allows you to select member or claim data to paste into a new claim submission.

– The **New** button allows you to start a new institutional claim.

Section 4: Dental Claim Billing Instructions

The Indiana Health Coverage Programs (IHCP) accepts only the *American Dental Association (ADA) 2012 Dental Claim Form* (*ADA 2012* claim form) for dental claims submitted on paper. Dental claims may also be submitted electronically using the *Health Insurance Portability and Accountability Act* (HIPAA)-compliant 837D transaction or the Provider Healthcare Portal (Portal).

The IHCP does not supply dental claim forms, and the forms are not available at in.gov/medicaid/providers. Providers can obtain dental claim forms from several sources, including the ADA at 1-800-947-4746. The IHCP returns claims submitted on any other claim form to the provider.

Types of Services Billed on Dental Claims

Table 7 shows the provider types and the types of services that can be billed on the *ADA 2012* claim form, the Portal dental claim, or the 837D electronic transaction.

Table 7 – Types of Services Billed on Dental Claims

Provider Type	Types of Services
Dentist (Type 27)	Dental services provided by: • General dentist practitioners • Endodontists • Oral surgeons • Orthodontists • Pediatric dentists • Periodontists • Prosthodontists
Medical clinic (Specialty 082)	Dental services
Dental clinic (Specialty 086)	Dental services

Rendering NPI Required on Dental Claims

All dental claims must include the rendering provider NPI in addition to the billing or group NPI. If more than one rendering provider performs services on the same patient on the same date of service, these services must be filed on separate paper claims. If billing electronically (on the Portal or 837D transaction), multiple rendering providers can be entered on the same claim at the claim detail level.

This requirement also applies to dental claim adjustment requests. If a dental claim or adjustment request is submitted without the appropriate rendering provider NPI, it will be denied. Denied claims or adjustment requests must be resubmitted with the necessary corrections.

Providers that have administrator access in the Portal can view a list of the rendering providers linked to the group and make updates to the list as needed. Providers can also contact Customer Assistance at 1-800-457-4584 to discuss any updates that need to be made to the provider group information.

For more information about NPI requirements, see the *National Provider Identifier and One-to-One Match* section.

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Dental Procedure Codes

Providers must bill dental services using Current Dental Terminology (CDT) procedure codes. Only CDT procedure codes can be billed on the *ADA 2012* claim form or its electronic equivalents. Up to 10 procedure codes can be used on a single *ADA 2012* paper claim form; up to 50 may be submitted on an 837D transaction or Portal dental claim. Currently, no modifiers are approved for use with the CDT code set.

Date-of-Service Definition

All claims must reflect a date of service. The date of service is the date the specific service was actually supplied, administered, dispensed, or rendered to the patient. For example, when rendering services for space maintainers or dentures, the date of service must reflect the date the appliance or denture is delivered to the patient. This requirement is applicable to all IHCP-covered services.

Guidelines for Completing the *ADA 2012* Claim Form

> *Note:* *The instructions provided in this section apply to the IHCP guidelines only and are not intended to replace instructions issued by the ADA. The official ADA dental claim form instruction manual can be accessed from the* ADA website *at ada.org.*

This section provides a brief overview of the instructions for completing the *ADA 2012* claim form. Noncompliant claims submitted for processing are returned to the provider.

ADA 2012 Claim Form – Field-by-Field Instructions

Table 8 describes each field (or *data element*) of the *ADA 2012* claim form. The table uses **bold** to indicate fields that are *required* or *required, if applicable*. The instructions refer to fields by the number found in the left corner of each box on the dental claim form. The narrative sequence moves from left to right, top to bottom, across the claim form.

> *Note:* *Each claim form must have all required fields completed, including a total dollar amount. Providers can list only one procedure code per detail line. If the number of services exceeds the number of detail lines allowed on the form, providers must complete an additional claim form.*

As described in the *Rendering NPI Required on Dental Claims* section, all dental providers are required to include their rendering NPI as well as their billing or group NPI. When two or more dentists are rendering services for a member, the providers must submit the claims on separate forms to expedite claim processing.

Figure 51 shows a sample copy of the *ADA 2012* claim form.

Table 8 – *ADA 2012* Claim Form Field Descriptions

Form Field	Narrative Description/Explanation
HEADER INFORMATION	
1	Type of Transaction (Mark all applicable boxes) – Mark the applicable boxes: • Statement of Actual Services • EPSDT/Title XIX (Early and Periodic Screening, Diagnosis, and Treatment) • Request for Predetermination/Preauthorization Optional.
2	**Predetermination/Preauthorization Number** – Enter the prior authorization number. If it is an emergency situation, write the word *Emergency* in this field. **Required, if applicable.**
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3	Company/Plan Name, Address, City, State, ZIP Code – Enter Medicaid as the payer being billed. Optional.
OTHER COVERAGE	
4	Dental? Medical? – Mark the Dental and/or Medical box to indicate whether the member has other dental or medical coverage, in addition to IHCP coverage. Optional.
5	Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) – If another insurance is available and the policyholder is other than the member indicated in field 20, provide the policyholder's name. Optional.
6	Date of Birth (MM/DD/CCYY) – If another insurance is available and the policyholder is other than the member indicated in field 20, provide the policyholder's birth date in MMDDCCYY format. Optional.
7	Gender – Mark the appropriate box: male (M) or female (F). Optional.
8	**Policyholder/Subscriber ID (SSN OR ID#)** – Enter the insured's Social Security number or other-insurance policy number. **Required, if applicable.**
9	**Plan/Group Number** – Enter the plan or group number of the other insurance. **Required, if applicable.**
10	**Patient's Relationship to Person Named in #5** – Select the appropriate box to indicate the relationship between the member and the person named in field 5. **Required, if applicable.**
11	**Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code** – Enter the requested information for the other insurance carrier. **Required, if applicable.**
POLICYHOLDER/SUBSCRIBER INFORMATION (FOR INSURANCE COMPANY NAMED IN #3)	
12	**Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code** – Enter the member's last name, first name, and middle initial as found on the member's IHCP identification card. **Required for field 12 or field 20.**
13	Date of Birth (MM/DD/CCYY) – Enter the member's date of birth. Optional.
14	Gender – Select the box for the member's gender. Optional.
15	**Policyholder/Subscriber ID (SSN OR ID#)** – This field accommodates 12 numeric characters. **The IHCP Member ID (also known as RID) is required for this field.**
16	Plan/Group Number **–** Not applicable.
17	Employer Name – Enter the name of the employer through which the member is insured. Optional.
PATIENT INFORMATION	
18	Relationship to Policyholder/Subscriber in #12 Above – Enter **X** in the Self box. Optional.
19	Reserved for Future Use.

Form Field	Narrative Description/Explanation
20	**Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code** – Enter the member's last name, first name, and middle initial as found on the member's IHCP identification card. **Required for field 12 or field 20.**
21	Date of Birth – Enter the member's date of birth. Optional.
22	Gender – Select the box for the member's gender. Optional.
23	**Patient ID/Account # (Assigned by Dentist)** – Enter the dental office internal patient number. **Required.**
RECORD OF SERVICES PROVIDED *Note: Fields 24–31 apply to each service detail for the claim (lines 1–10).*	
24	**Procedure Date** – Enter the date (in MM/DD/CCYY format) that the service was rendered. **Required.** *Note: Date of service is the date the specific services were actually supplied, administered, dispensed, or rendered to the patient. For example, this date will reflect the date the denture or space maintainer is delivered to the patient.*
25	**Area of Oral Cavity** – Enter the appropriate code to indicate the affected area of the oral cavity for the service rendered. (See the *Dental Services* module for a list of valid area-of-oral-cavity codes.) **Required, if applicable.** .) (If the procedure code itself identifies a specific area of the oral cavity, or if the service does not relate to any portion of the oral cavity, leave this field blank.)
26	**Tooth System** – Enter **JP** to designate the ADA Universal/National Tooth Designation System. **Required, if applicable.**
27	**Tooth Number(s) or Letter(s)** – Enter the tooth number or letter for the service rendered (1–32 for permanent dentition and A–T for primary dentition). Required for any procedure performed on an individual tooth. **Required, if applicable.**
28	**Tooth Surface** – Enter the one-letter tooth surface code (or codes) for the service rendered. (See the *Dental Services* module for a list of valid tooth surface codes.) **Required, if applicable.**
29	**Procedure Code** – Enter the appropriate ADA CDT procedure code for the service provided (one per line). **Required.**
29a	Diag. Pointer – Enter the letter(s) from field 34a that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first. Optional. If this field is completed for any service, then fields 34 and 34a are required.
29b	**Qty.** – Enter the number of times (01-99) the procedure identified in field 29 was delivered to the patient on the date of service in field 24. **Required.**
30	Description – Optional.
31	**Fee** – Enter the amount charged for each procedure code listed (lines 1-10). Eight digits are allowed, including two decimal places. **Required.**
31a	Other Fee(s) – Not used.
32	**Total Fee** – Enter the total of all the individual detail line charges. Eight digits are allowed, including two decimal places. **Required.**

Form Field	Narrative Description/Explanation
33	**Missing Teeth Information** (Place an 'X' on each missing tooth) – Mark the diagram as directed. **Required, if applicable**.
34	**Diagnosis Code List Qualifier** – Enter AB for ICD-10. **Required if field 29a (diagnosis pointer) is completed for any service line.**
34a	**Diagnosis Code(s)** – Enter diagnosis code(s) in A, B, C, D (up to four, with the primary adjacent to the letter "A"). **Required if field 29a (diagnosis pointer) is completed for any service line.**
35	**Remarks** – Enter **only** the amount paid by a prior payer. All commercial payments are required in this field. **Required, if applicable.** *Note: If another insurer made a payment on the claim (including payments of zero), providers must complete and submit the [IHCP Third-Party Liability (TPL)/ Medicare Special Attachment Form](#) along with the ADA 2012 paper claim form. The special attachment form should include all prior payments made at the detail level. The form and instructions for completing it are available on the [Forms](#) page at in.gov/medicaid/providers.* *For documentation requirements related to IHCP claims when the primary carrier denied the claim or paid at zero, see the [Documenting Denied or Zero-Paid Claims](#) section.*
AUTHORIZATIONS	
36	Patient/Guardian Signature, Date – Optional.
37	Subscriber Signature, Date – Optional.
ANCILLARY CLAIM/TREATMENT INFORMATION	
38	**Place of Treatment**– Enter the place-of-service (POS) code for the type of facility where treatment was rendered. **Required.** *Note: Use the same POS codes for this field as are used for professional claims. For a list of POS codes, go to the [Place of Service Code Set](#) page on the CMS website at cms.hhs.gov.*
39	**Enclosures (Y or N)** – Enter Y or N (for *yes* or *no*) to indicate whether or not attachments are being submitted with the claim. **Required if applicable.**
40	**Is Treatment for Orthodontics?** – Mark Yes or No. If Yes is marked, provide the additional information requested in field 41 and 42. **Required if applicable.**
41	**Date Appliance Placed (MM/DD/CCYY) –** Indicate the date an orthodontic appliance was placed. This information should also be reported in this field for subsequent orthodontic visits. **Required if applicable.**
42	**Months of Treatment** – Enter the total number of months required to complete the orthodontic treatment. (*Note: The number entered here should be the total number of months from the beginning to the end of the treatment plan, not the number of months remaining.*) **Required if applicable.**
43	**Replacement of Prosthesis** – Mark **Yes** or **No**: • If the claim *does not involve* a prosthetic restoration or is for the *initial placement* of a crown or a fixed or removable prosthesis, mark **No** and proceed to field 45. • If the patient has previously had these teeth replaced by a crown or a fixed or removable prosthesis (for example, bridges and dentures), or the claim is to replace an existing crown, mark **Yes** and complete field 44. **Required if applicable.**

Form Field	Narrative Description/Explanation
44	**Date of Prior Placement (MM/DD/CCYY)** – Enter the date of prior placement of prosthesis. **Required if Yes is marked in field 43.**
45	**Treatment Resulting From** – Mark the appropriate box to indicate whether the treatment is resulting from occupational illness/injury, an auto accident, or another type of accident. **Required, if applicable.**
46	**Date of Accident (MM/DD/CCYY)** – Enter date. **Required, if applicable.**
47	**Auto Accident State** – Enter state of auto accident. **Required, if applicable.**
BILLING DENTIST OR DENTAL ENTITY	
48	**Name, Address, City, State, Zip Code** – Enter the billing provider office location name, address, city, state, and nine-digit ZIP Code+4. **Required.**
49	**NPI** – Enter the 10-digit numeric NPI of the billing or group provider. **Required.**
50	License Number – Leave field blank.
51	SSN or TIN – Optional.
52	Phone Number – Optional.
52a	**Additional Provider ID** – Enter the taxonomy code for the billing provider NPI. **Required if needed to establish one-to-one NPI/IHCP Provider ID match, if the provider has multiple locations.**
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53	Signed (Treating Dentist) – IHCP participating providers must have a signature on file; therefore, this field is optional. Date – Provide the date the claim was submitted, in an MMDDYYYY format. Optional.
54	**NPI** – Enter the rendering provider's NPI. **Required.** *Note:* *If two or more dentists perform services on the same patient on the same date of service, these services must be filed on separate claims.*
55	License Number – Optional.
56	Address, City, State, Zip Code – Enter the rendering provider address. Optional.
56a	Provider Specialty Code – Enter the rendering provider taxonomy code for the NPI. Optional.
57	Phone Number – Optional.
58	Additional Provider ID – Leave field blank.

Figure 51 – *ADA 2012 Dental Claim Form*

ADA American Dental Association® **Dental Claim Form**

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**")

A _____ C _____
B _____ D _____

31a. Other Fee(s)

32. Total Fee $0.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature　　　　Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature　　　　Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number

52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment

43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist)　　　　Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number

58. Additional Provider ID

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J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

Guidelines for Submitting Dental Claims Electronically

The IHCP accepts dental claims submitted electronically through an 837D transaction or via the Portal.

In compliance with HIPAA standards, *Core*MMIS accepts 50 service details on the Portal dental claim or 837D transaction.

Providers have the ability to send attachments for claims that are submitted using the Portal or 837 transaction. Examples of attachments include: periodontal charts, explanations of benefits (EOBs), and past filing documentation. The Portal allows attachments to be uploaded and submitted with the claim. For 837 transactions, attachments must be sent separately by mail, as described in the *Mailing Paper Attachments for Electronic Claims* section.

The following section provides a step-by-step example of the Portal claim-submission process for a dental claim.

For details about completing an 837D electronic transaction, see the following resources:

- *Electronic Data Interchange* module

- 837D Implementation Guide, available for purchase and download through the Washington Publishing Company website at wpc-edi.com

- 837D Companion Guide, available from the *IHCP Companion Guides* page at in.gov/medicaid/providers

For general information about electronic billing, see the *Electronic Claims* section of this module.

Portal Dental Claim Submission Process

> *Note: For general information about submitting claims via the Portal, see the Submit Claim section.*

To submit dental claims via the Portal, log in, select **Claims > Submit Claim Dental**, and complete these three steps as described in the following sections:

- Enter provider, patient, and claim information.

- Enter diagnosis codes, missing teeth, and information about other insurance (TPL).

- Enter service details, attachments, and claim notes.

Step 1: Provider, Patient, and Claim Information

Step 1 of submitting a dental claim entails adding provider, patient, and claim information.

Figure 52 – Submit Dental Claim: Step 1

Provider Information Section

The *Provider Information* section displays the billing provider's NPI or Provider ID and name. This section also allows users to identify the rendering provider and the service facility location.

The NPI of the rendering provider (referred to as the "treating dentist" on the *ADA 2012*) is required for all detail claims. If two or more dentists perform services on the same patient on the same date of service, the applicable rendering providers can be identified at the service detail level (see Figure 62).

Figure 53 – Provider Information Section (Dental Claim)

Users can type the rendering provider's information directly into the fields or click the magnifying glass icon to search for the provider by ID, name, or organization. When the desired provider is selected from the search results, that provider's information automatically populates the appropriate fields.

Patient Information Section

The *Patient Information* section is intended to collect information about the member for whom the claim is being submitted and associates all the plan and benefit information to that particular member.

Figure 54 – Patient Information Section (Dental Claim)

Patient Information
Enter Member ID, Date of Birth and at least one character of First and Last Name

*Member ID		
*Last Name		*First Name
Birth Date		

> Note: If the system does not find a match based on Member ID, first name, and last name, the error message, "Member not found," is displayed. The claim submission process will not be able to continue until valid information is entered.

Claim Information Section

The *Claim Information* section is intended to collect general information about the claim.

Figure 55 – Claim Information Section (Dental Claim)

Claim Information
General Claim Information Instructions

Emergency ☐

Accident Related [▾]   Accident Date [   ]

*Place of Treatment [11-Office ▾]   *Patient Number [   ]

Special Program [▾]   Authorization Number [   ]

*Does the provider have a signature on file? ◉ Yes ○ No

*Does the provider accept assignment for claim processing? ◉ Yes ○ No

*Are benefits assigned to the provider by the patient or their authorized representative? ◉ Yes ○ No ○ N/A

*Does the provider have a signed statement from the patient releasing their medical information? ◉ Yes ○ No

Include Other Insurance ☐   Total Charged Amount $0.00

[Continue]   [Cancel]

If the claim is for an emergency service, the **Emergency** checkbox must be selected.

The **Patient Number** is the unique number assigned by the provider to use internally to identify the person who received the services.

For the **Place of Treatment**, select the Place of Service (POS) code for the type of facility where the treatment was rendered.

If the member has insurance coverage through another carrier, select the **Include Other Insurance** box located at the bottom of the page before clicking Continue. This option allows you to enter coordination of benefits (COB) information (if you do not check this box, the *Other Insurance Details* panel in Step 2 will not be visible).

Completing Step 1

After you enter all required information for Step 1 and are ready to advance to Step 2 of the dental claim-submission process, click **Continue**.

Step 2: Diagnosis Codes, Missing Teeth, and Other Insurance (TPL)

Before entering information for Step 2, review a summary of the provider, patient, and claim information you entered in Step 1. This summary is located at the top of the *Submit Dental Claim: Step 2* panel.

Figure 56 – Submit Dental Claim: Step 2 –Summary Information

Diagnosis Codes

The Diagnosis Codes panel is available but optional.

Figure 57 – Diagnosis Codes Panel

Missing Teeth

If reporting missing teeth, type the tooth number in the Tooth Number field and click **Add** (see Figure 58). Repeat this process to enter additional tooth numbers. This field is required if applicable.

Figure 58 – Missing Teeth Panel

Other Insurance Details

If other insurance details or TPL insurance information for a member is already in the Portal, that information will automatically populate fields in the *Other Insurance Details* panel.

Figure 59 – Other Insurance Details Panel (Dental Claim)

You can add, remove, or edit information in the *Other Insurance Details* panel.

- Click **Remove** to delete any unneeded carriers from the claim.

- Click the *hyperlinked number* in the # column to update a carrier's information.

- Click **[+]** *Click to add a new other insurance* to expand the section where you can add new insurance information. After all information is entered, click **Add Insurance** to add the new carrier.

Figure 60 – Add a New Insurance Carrier

> *Note:*   *The carrier ID is the identification number the insurance company uses in electronic claim submission. If the carrier ID is unknown, type the carrier name the same as it is in the "Carrier Name" field.*

Completing Step 2

After you enter all required information for Step 2 of the dental claim submission process and are ready to advance to Step 3, click **Continue**.

Step 3: Service Details, Attachments, and Claim Note Information

Before entering information for Step 3, review a summary of the information entered during Step 1 and Step 2. This summary is located at the top of the *Submit Dental Claim: Step 3* panel.

Figure 61 – Submit Dental Claim: Step 3 – Summary Information

Service Details

The *Service Details* panel is used to enter information for each service detail, such as service date, procedure code, and number of units. Click **Add** after completing the information for a service detail. Up to 50 detail lines are allowed per dental claim.

Figure 62 – Service Details Panel (Dental Claim)

In the **Oral Cavity Area** field, select the appropriate code to indicate the affected area of the oral cavity for the service rendered. This field is required, if applicable. However, if the procedure code itself identifies a specific area of the oral cavity, or if the service does not relate to any portion of the oral cavity, this field should be left blank. See the *Dental Services* module for information about area-of-oral-cavity codes.

In the **Tooth Number** field, select the tooth number or letter for the service rendered. This field is required for any procedure performed on an individual tooth. Each applicable tooth-surface code must also be selected, if applicable, in the **Tooth Surface** fields.

If the rendering provider was entered on the header level of the claim, it does not need to be entered on the *Service Details* panel.

Other Insurance for Service Detail

When a dental claim has been submitted to and processed by a third-party payer, the *Other Insurance for Service Detail* section is required. TPL information, including the amount paid by the other carrier, must be entered for every procedure code.

To add other insurance information to each service line, follow these steps:

1. Click the hyperlinked number for each service line in the *Service Details* panel, and you will be prompted to provide the *Other Insurance for Service Detail* information.

Figure 63 – Other Insurance for Service Detail

2. Select the carrier name from the Other Carrier drop-down menu and enter information in the TPL/Medicare Paid Amount and the Paid Date fields.

3. Click **Add**.

4. Click **Save**.

Attachments

The *Attachments* panel is used to upload supporting documents electronically or to indicate that you intend to mail the appropriate documentation.

Figure 64 – Attachment Transmission Methods

> Note: If you plan to upload an attachment, be aware that the attachment file size limit is 5 MB, and valid file types for upload include: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif and .tiff.

1. Select **FT–File Transfer** to upload a file or **BM–By Mail** to send documents to the IHCP by mail.

2. Identify the attachment being mailed or uploaded:
   – If sending the attachment by mail, create a unique attachment control number (ACN) and enter that number in the Control # field (see Figure 65). This number **must** match the number submitted on the *IHCP Claims Attachment Cover Sheet* (available on the *Forms* page at in.gov/medicaid/providers) that is mailed with the documentation. See the *Mailing Paper Attachments for Electronic Claims* section for details.
   – If sending the attachment using the file transfer method, click Browse to locate the file you wish to upload (see Figure 66).

Figure 65 – Attachments Panel Using By Mail Transmission Method

Figure 66 – Attachments Panel Using File Transfer Method

3. Select the appropriate option from the Attachment Type drop-down menu.

4. Click **Add** after selecting each individual document to attach.

Claim Note Information

Although the fields in the *Claim Note Information* panel are not required, they can be used if needed to provide clarifying information about the claim as follows:

1. Select **Additional Information** from the Note Reference Code drop-down menu.

2. Enter any necessary information in the Note Text field.

3. Click **Add** to add the claim note.

Figure 67 – Claim Note Information Panel

See the *Claim Notes* section for more information about using claim notes.

Submit for Final Preview

After you have provided all the information for the claim, click **Submit** to proceed to the final preview, from which you can modify or submit the claim.

Confirm Claim

The Portal displays the claim information for review before you confirm your submission.

Figure 68 – Confirm Dental Claim Information

1. Review the information and then select the appropriate option from the bottom of the page:
    –   If you discover that you need to edit the claim information, use the **Back to Step** buttons to navigate to the appropriate step and edit the desired information.
    –   Click **Print Preview** to print a copy of the claim information being submitted.
    –   Click **Cancel** if you decide not to submit the claim. When you choose to cancel the claim submission, data entered during the process will be lost, and the claim data will not be submitted.
    –   If, after reviewing the information, you are ready to submit the claim, click **Confirm**.

2. After you click **Confirm** to submit the claim for processing, the Portal displays a claim receipt with the Claim ID and current claim status.

> *Note: Use the Claim ID as the reference to check the status of your claim or any time you reference this claim in an inquiry.*

Figure 69 – Dental Claim Submission Confirmation

3. The *Submit Dental Claim: Confirmation* panel also includes the following options:

    –   The **Print Preview** button allows you to view and print a copy of your claim receipt.

    –   The **Copy** button allows you to select member or claim data to paste into a new claim submission.

    –   The **New** button allows you to start a new dental claim.

Section 5: Coordination of Benefits

Many Indiana Health Coverage Programs (IHCP) members have other insurance in addition to the IHCP benefits. This other insurance may be a commercial group plan through the member's employer, an individually purchased plan, Medicare, or insurance available because of an accident or injury. The IHCP supplements other available coverage and is primarily responsible for paying only the medical expenses that other insurance does not cover. If a member does have additional insurance coverage, known as third-party liability (TPL), the provider is responsible for billing the primary insurance carrier first and then sending any subsequent requests to the IHCP indicating any payments made by the primary insurance carrier.

See the *Third-Party Liability* module for more information.

Reporting Other Insurance Information on IHCP Claims

Depending on the claim type, the IHCP has specific requirements for reporting other insurance. Information about other insurance must be reported for all claims where another carrier was billed. For certain claim types, this information must be reported for each detail of the claim as well as for the claim as a whole.

Information about payments made by anther insurer (including payments of zero, due to the full amount being applied to a deductible, coinsurance, or copayment), is required **at the detail level** for the following types of claims:

- Dental (*ADA 2012* claim form, Portal dental claim, or 837D transaction)

- Home health and home health crossover, including hospice (*UB-04* claim form, Portal institutional claim, or 837I transaction with a corresponding type of bill)

- Outpatient and outpatient crossover (*UB-04* claim form, Portal institutional claim, or 837I transaction with an outpatient type of bill)

- Professional (also known as *medical* or *physician*) and professional crossover (*CMS-1500* claim form, Portal professional claim, or 837P transaction)

> *Note: Providers using paper claim forms (ADA 2012, UB-04, or CMS-1500) to bill the IHCP for claims where another carrier made a payment (including payments of zero) must submit this detail-level information using the IHCP TPL/Medicare Special Attachment Form. The form and instructions for completing it are available on the Forms page at in.gov/medicaid/providers. The instructions include a link to a Quick Reference Guide explaining in detail how to submit paper claims with detail-level TPL information, both for Medicare crossover claims and for other insurance TPL.*

Reporting Other Insurance on 837 Transactions

The 837I, 837P, and 837D transactions all support the submission of TPL and Medicare information at both the header and detail levels:

- Third-party payment information, including Medicare information, is always submitted in the AMT segment in the 2320 loop.

- If applicable, detail paid amounts are submitted in the SVD segment in the 2430 loop.

- Medicare deductible, coinsurance, copayment, and blood deductible are submitted in the CAS segments at either the header or detail level, depending on the claim type.

Reporting Other Insurance on Provider Healthcare Portal Claims

Providers may enter Medicare or other TPL information on Provider Healthcare Portal (Portal) claims as follows:

- Select the Include Other Insurance box in Step 1 of the claim submission process.

- Enter carrier information, including total TPL/Medicare paid amount, in the *Other Insurance Details* panel in Step 2 of the process.

  If information about a member's other insurance already exists in the system, the information will automatically appear in the *Other Insurance Details* panel.
  - Click **Remove** to delete any nonapplicable carriers from the claim.
  - Click **[+]** *Click to add a new other insurance* to add information for a new carrier.
  - Click a carrier number to update the information for that carrier.

- For Medicare or Medicare Replacement Plan crossover claims, after adding the other carrier, click the hyperlinked number for that carrier in the # column of the Other Insurance Details table and enter the Claim Adjustment Group Code, Reason Code, and Adjustment Amount information in the *Claim Adjustment Details* panel. Then click **Add** and then **Save**.

- If detail-level Medicare or TPL information is required for the claim type, enter it during Step 3 of the process as follows:

  1. Enter the specific service information (such as date of service, procedure code, units of service) in the *Service Details* panel and click **Add**.

  2. Select the detail number and enter detail-level Medicare or other TPL information in the *Other Insurance for Service Details* panel and click **Add**.

  3. Select the detail number once again to access the Other Insurance for Service Details table, and then select the carrier number to access the *Claim Adjustment Details* panel to enter the Claim Adjustment Group Code, Reason Code, and Adjustment Amount information for the service detail selected and then click **Add**.

  4. Repeat this process for each detail on the claim and then click **Save**.

Reporting Other Insurance on Paper Claims

The *CMS-1500*, *UB-04*, and *ADA 2012* paper claim forms do not provide a field for submitting Medicare or other TPL information at the detail level. Therefore, the IHCP encourages providers to use either an 837 electronic transaction or the Portal for submitting claims that require detail-level Medicare or other TPL information. For providers that choose to continue to submit claims on paper, the IHCP has developed the *IHCP TPL/Medicare Special Attachment Form*. This supplemental form **must be completed and submitted** along with all paper claims that require detail-level TPL or Medicare information. This form and instructions for completing the form are available on the *Forms* page at in.gov/medicaid/providers.

Providers should enter header-level TPL and Medicare information in the appropriate field on the respective claim form. See the *UB-04 Claim Form – Field-by-Field Instructions, CMS-1500 Claim Form – Field-by-Field Instructions*, and *ADA 2012 Claim Form – Field-by-Field Instructions* sections of this module for instructions.

Documenting Denied or Zero-Paid Claims

If a primary insurer makes a payment on a claim, providers are only required to enter the amount of that third-party payment when submitting the claim (including, when applicable, the *IHCP TPL/Medicare Special Attachment Form*) to the IHCP. No further documentation is required.

However, if a primary insurer *denies* the claim, the provider must submit proof of a valid primary insurance denial when submitting the secondary claim to the IHCP. The *IHCP TPL/Medicare Special Attachment Form* is not used for denied claims. For primary insurers other than Medicare or a Medicare Replacement Plan, additional proof is also required if the primary insurer *pays zero* on the claim (for example, due to the full amount being applied to a deductible or copayment).

The provider has two options for providing this proof:

- Submit a hard copy of the primary insurance EOB (or equivalent document) as an attachment to the claim. (For Medicare Replacement Plan EOBs, **Medicare Replacement Plan** should be written on the top of the attachment.) Providers enter the zero paid amount on the claim and indicate that an attachment to the claim exists. The claim will suspend for manual review, and a specialist will examine the EOB and determine if the denial or zero payment is valid. Providers can submit a copy of the primary insurance EOB with the IHCP claim in one of these ways:
  – Uploaded as an attachment to the claim submitted on the Portal
  – Mailed separately as a paper attachment to an electronic claim, following the instructions in the *Mailing Paper Attachments for Electronic Claims* section of this module
  – Attached to the paper claim submitted by mail

- Submit the adjustment reason code (ARC) from the primary insurance EOB with the claim as follows:*
  – In the *Claim Adjustment Details* panel of the Portal claim
  – On the CAS segment of the 837 transaction
  – On the *IHCP TPL/Medicare Special Attachment Form* submitted with the paper claim.

> *Note **The option to submit the ARC in lieu of attaching an EOB does not apply to Medicare or Medicare Replacement Plan** claims. For claims that were denied by Medicare or a Medicare Replacement Plan, a copy of the EOB or EOMB must be attached to the IHCP claim.*

Table 9 provides a list of ARCs that the IHCP has deemed to be valid ARCs for denial or zero payment. If a detail submitted on a claim has a primary carrier payment amount of zero, the provider should still enter the zero paid amount on the claim. If the provider includes a valid ARC for denial or zero payment from the primary insurer (other than Medicare or Medicare Replacement Plan), the system accepts the zero payment as valid. The provider is required to maintain a copy of the primary insurance EOB and is expected to be able to produce it in the event of a back-end audit.

Table 9 – Valid Adjustment Reason Codes

ARC	Description
1	Deductible amount.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.

ARC	Description
19	This is a work-related injury/illness and thus the liability of the worker's compensation carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
31	Patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
49	This service is noncovered, because it is a routine/preventive exam or a diagnostic/screening procedure performed in conjunction with a routine/preventive exam.
50	These services are noncovered because this is not deemed a "medical necessity" by the payer.
51	These services are noncovered because this is a pre-existing condition.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
96	Noncovered charge(s). At least one Remark Code must be provided (may be either the National Council for Prescription Drug Programs [NCPDP] Reject Reason Code or Remittance Advice Remark Code that is not an ALERT).
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
119	Benefit maximum for this time period or occurrence has been reached.
146	Diagnosis was invalid for the date(s) of service reported.
149	Lifetime benefit maximum has been reached for this service/benefit category.
160	Injury/illness was the result of an activity that is a benefit exclusion.
166	These services were submitted after this payer's responsibility for processing claims under this plan ended.
167	These diagnoses are not covered.
168	Services have been considered under the patient's medical plan. Benefits are not available under this dental plan.
171	Payment is denied when performed/billed by this type of provider in this type of facility.

ARC	Description
177	Patient has not met the required eligibility requirements.
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
185	The rendering provider is not eligible to perform the service billed.
188	This product/procedure is only covered when used according to FDA recommendations.
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
198	Precertification/notification/authorization/pre-treatment exceeded.
200	Expenses incurred during lapse in coverage
201	Patient is responsible for amount of this claim/service through "set aside arrangement" or other agreement. (**Use only with Group Code PR.**) At least one Remark Code must be provided (may be either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT). -
202	Non-covered personal comfort or convenience services.
203	Discontinued or reduced service.
204	This service/equipment/drug is not covered under the patient's current benefit plan.
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA.)
211	National Drug Codes (NDCs) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered.
215	Based on subrogation of a third-party settlement.
216	Based on the findings of a review organization.
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.
231	Mutually exclusive procedures cannot be done in the same day/setting.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
234	This procedure is not paid separately.
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements.
245	Provider performance program withhold.
246	This nonpayable code is for required reporting only.
247	Deductible for professional service rendered in an institutional setting and billed on an institutional claim.
256	Service not payable per managed care contract.
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state, or local authority may cover the claim/service.
269	Anesthesia not covered for this service/procedure.

ARC	Description
273	Coverage/program guidelines were exceeded.
274	Fee/service not payable per patient Care Coordination arrangement.
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, copayment) not covered. (Use only with Group Code PR.)
276	Services denied by the prior payer(s) are not covered by this payer.
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.
B1	Noncovered visits.
B5/272	Coverage/program guidelines were not met.
B5/273	Coverage/program guidelines were exceeded.
B14	Only one visit or consultation per physician per day is covered.
W3/P14	The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
W8/P19	Procedure has a relative value of zero in the jurisdiction fee schedule; therefore, no payment is due. To be used for Property and Casualty only.
W9/P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.

Section 6: Special Billing Instructions for Specific IHCP Benefit Plans

Some Indiana Healthcare Coverage Programs (IHCP) benefit plans require special billing procedures. This section provides billing instructions for the following benefit plans:

- Medical Review Team

- Package E – Emergency Services Only

- Emergency Services Only (ESO) Coverage with Pregnancy Coverage (Package B)

- Medicaid Inpatient Hospital Services Only (for inmates)

For billing instructions specific to other benefit plans, see the appropriate module in the *Program-Specific Modules* section of the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers.

Medical Review Team Billing

Medical Review Team (MRT) claims must be billed using the following procedures:

- All group, billing, and rendering providers must be valid participants in the MRT program.

- Providers must submit MRT claims via a *CMS-1500* claim form, the Provider Healthcare Portal (Portal) professional claim, or the 837P transaction within 180 days of the date of service.
    - Providers submitting claims via the Portal must meet the technical requirements for the Portal access and have a valid Portal account and password, as described in the *Provider Healthcare Portal* module. Providers that currently have a Portal account and password do not need an additional account and password to submit claims for MRT.
    - New providers wanting to use the 837P transaction must complete, submit, and obtain prior approval of their vendor's software, trading partner ID, logon ID, and password. Providers should allow one week to process vendor and account information. Instructions for account setup are available in the *Companion Guide – 837 Professional Claims and Encounters Transaction* from the *IHCP Companion Guides* page at in.gov/medicaid/providers. Providers that are currently transmitting claims using the 837P transaction are not required to submit a second application to submit claims for MRT.

- Providers must properly identify and itemize all services rendered.
    - For assistance in selecting the procedure code that best describes the MRT services rendered, see *Medical Review Team Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.
    - All MRT services must be billed with the modifier SE – *State and/or federally funded programs/services* on the claim detail. This requirement applies to all claims for MRT services, and all provider-initiated adjustments or replacement claims for all MRT services.

- Providers cannot submit MRT claims for payment with a claim for Medicaid or services for any other IHCP program.

- Providers must submit MRT claims using the member's 12-digit IHCP Member ID (also known as RID).

- MRT claims are subject to all edits and audits not excluded by MRT program requirements.

- MRT payment information is available on the Portal-based Remittance Advice (RA) or the 835 electronic transaction.

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- MRT claim-processing information is reflected on the 276/277 Claim Status Request and Response Transactions. Providers can inquire on the claim status request and response by sending a secure correspondence message on the Portal.

- At no time will an applicant bear financial responsibility for an MRT claim if the services were requested by the MRT or county caseworker. MRT claims are paid even if the disability application is denied.

When providers have questions about procedure codes used for billing MRT services or the resource-based relative value scale (RBRVS)/Maximum Fee Schedule, or when they require clarification about a specific code, they should use the provider resources listed in the *Introduction to the IHCP* module. The complete Professional Fee Schedule is accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Emergency Services Only (Package E) Billing

For emergency services rendered to members enrolled in benefit Package E, providers must indicate in the proper field of the claim that the service qualifies as an emergency service as defined in the *Emergency Services* module. is an emergency service. Table 10 provides instructions for completing these fields for paper claims or the Portal.

Table 10 – Package E Billing Instructions

Claim Type	Paper Claim Form Instructions	Portal Claim Instructions
Professional	On the *CMS-1500* claim form*:* In field 24C: EMG, enter **Y** (for *yes*) for each applicable detail to indicate that it was an emergency service.	On the Portal professional claim: In the *Service Details* panel in Step 3, select the EMG box for each applicable detail to indicate that it was an emergency service.
Dental	On the *ADA 2012* claim form*:* In field 2: PREDETERMINATION/ PREAUTHORIZATION NUMBER, enter the word **Emergency** to indicate that the claim is for an emergency situation. In field 29: PROCEDURE CODE, enter only appropriate procedure codes that have been designated by the IHCP as emergency dental services. If applicable, in field 45: TREATMENT RESULTING FROM, indicate if the treatment is the result of an occupational illness or injury, an auto accident, or other accident.	On the Portal dental claim: In the C*laim Information* panel in Step 1, select the Emergency box to indicate that the claim is for an emergency situation. Also in the *Claim Information* panel in Step 1, if the treatment is a result of an occupational illness or injury, auto accident, or other accident, select the appropriate option from the drop-down menu in the Accident Related field. In the *Service Details* panel in Step 3, enter only appropriate procedure codes that have been designated by the IHCP as emergency dental services in the Procedure Code field.
Inpatient	On the *UB-04* claim form for inpatient claims: In field 14: ADMISSION TYPE, enter a type code of **1** for an emergency admission.	On the Portal institutional claim, for inpatient billing: In the *Claim Information* panel in Step 1, enter **1 – Emergency** in the Admission Type field.

Claim Type	Paper Claim Form Instructions	Portal Claim Instructions
Outpatient	On the *UB-04* claim form for outpatient claims: In field 67: [PRINCIPAL DIAGNOSIS CODE], enter the appropriate emergency diagnosis code.	On the Portal institutional claim, for outpatient billing: In the *Diagnosis Codes* panel in Step 2, enter the appropriate emergency diagnosis code in the first (primary) position.
IHCP Drug Claim Form	Field 03: EMERGENCY – Enter **YES** for emergency services. Field 11: DAYS SUPPLY – Days supply must be less than or equal to 4 for emergency services.	Not applicable
IHCP Compounded Prescription Claim Form	Field 04: EMERGENCY – Enter **YES** for emergency services. Field 13: DAYS SUPPLY – Days supply must be less than or equal to 4 for emergency services.	Not applicable

The IHCP does not cover nonemergency services furnished to individuals enrolled in Package E. The patient may be billed for these services if notified of noncoverage prior to rendering care. See the *Provider Enrollment* module for information about billing an IHCP member for noncovered services.

Emergency Services Only Coverage with Pregnancy Coverage (Package B) Billing

For services rendered to members enrolled in ESO Coverage with Pregnancy Coverage (Package B), providers must do one of the following:

- Indicate in the appropriate field on the claim that the service rendered meets the definition of an emergency service as defined in the *Emergency Services* module. See the billing instructions in the *Emergency Services Only (Package E) Billing* section.

- Include a diagnosis code that indicates the service was related to prenatal or postpartum treatment. For additional billing instructions for pregnancy-related services, see the *Obstetrical and Gynecological Services* module.

Medicaid Inpatient Hospital Services Only (for Inmates) Billing

The IHCP covers inpatient services for IHCP-eligible inmates admitted as inpatients to an acute care hospital, nursing facility, or intermediate care facility. Reimbursement is available only for services provided between inpatient admission and discharge, and for physician services provided during an emergency department visit that results in an inpatient admission. When an inmate is admitted to the inpatient facility, the correctional facility medical provider will assist the inmate in completing the *Indiana Application for Health Coverage*. Prior authorization is not required for an inmate's inpatient admission.

Billing providers should follow current procedures for submitting claims to the correctional facility medical provider until that provider notifies the billing provider that the inmate is eligible for IHCP coverage, indicating that the claim should be billed to the IHCP, instead. In instances where eligibility is determined after the correctional facility medical provider has made payment, an adjusted RA will be issued, indicating IHCP eligibility and recouping payment for the eligible inmate.

Upon notification of the inmate's IHCP eligibility, billing providers must verify member eligibility and submit claims to the IHCP using their standard transaction method. The IHCP Eligibility Verification System (EVS) indicates a benefit plan of *Medicaid Inpatient Hospital Services Only* for inmates with this coverage. The correctional facility medical provider will retroactively review claims submitted to the IHCP and will initiate adjustments for unapproved services. If unapproved services were paid by the IHCP, the current IHCP recoupment process will be followed.

The following provider specialties are allowed to bill for inpatient or qualifying emergency department services for inmates:

- Hospitals with the following provider specialties may bill for inpatient services for inmates:
    - 010 – *Acute Care*
    - 012 – *Rehabilitation*
    - 013 – *Long Term Acute Care*

    Institutional providers (hospitals, nursing facilities, or intermediate care facilities) bill for inpatient or qualifying emergency department services on a *UB-04* claim form or electronic equivalent (Portal institutional claim or 837I transaction).

- Provider specialties appropriate to bill for services rendered during an inpatient stay or qualifying emergency department visit may bill for services rendered to inmates on a *CMS-1500* claim form or electronic equivalent (Portal professional claim or 837P transaction).

> *Note: Reimbursement is available only to facilities that are not primarily operated by law enforcement authorities. Facilities primarily operated by law enforcement authorities are considered correctional facilities.*

For more information about eligibility and services covered under this benefit plan, see the *Member Eligibility and Benefit Coverage* module.

Section 7: Ordering, Prescribing, and Referring Practitioner Requirements

When providing medical services or supplies resulting from an order, prescription, or referral, federal regulations require providers to include the National Provider Identifier (NPI) of the ordering, prescribing, or referring (OPR) practitioner on Medicaid claims. Reimbursement to the billing provider requires the OPR practitioner to be enrolled in Medicaid. For more information about enrolling as an OPR practitioner, see the *Provider Enrollment* module.

To comply with these provisions, the IHCP claim adjudication process verifies both the presence of a valid OPR practitioner NPI and the OPR practitioner's enrollment in the IHCP. Medical claims will be denied if an NPI for the OPR practitioner is not present on the claim or if the OPR practitioner is not enrolled as an IHCP provider.

Inclusion of an NPI for the OPR practitioner applies to paper claims, electronic claims submitted via the Provider Healthcare Portal (Portal), and 837 *Health Insurance Portability and Accountability Act* (HIPAA) 5010 or National Council for Prescription Drug Programs (NCPDP) D.0 electronic transactions. Reporting the OPR practitioner's NPI applies to Medicare crossover, third-party liability (TPL), and Medicaid primary claims.

For prescriptions written by a prescriber within a hospital or a federally qualified health center (FQHC), the billing provider may use the NPI of the hospital or FQHC in the prescriber field. If the prescriber is not enrolled, a pharmacist may dispense and be reimbursed for up to a 72-hour supply of a covered outpatient drug as an "emergency supply."

Using inaccurate NPIs, such as using one prescriber's NPI on a claim for a prescription from a different prescriber, is strictly forbidden and will subject the pharmacy provider to recoupment of payment and possible sanction. The Family and Social Services Administration (FSSA) and its contractors will monitor providers' compliance via postpayment review and, if necessary, will refer noncompliant providers to the Indiana Medicaid Fraud Control Unit (MFCU).

Verifying OPR Enrollment

IHCP providers that render services or supplies should use the OPR Provider Search Tool (accessible from in.gov/medicaid/providers) to verify IHCP enrollment of the ordering, prescribing, or referring practitioner before services or supplies are provided.

> *Note: The OPR search is date-of-service specific. Entering a single date of service for a span date is not recommended. For the most accurate enrollment status information, providers are advised to perform separate searches for each date in the date span.*

Specialties Required to Include OPR NPI on All Claims

Claims from the following specialties will not adjudicate without the NPI of the provider that ordered, prescribed, or referred the services or supplies:

- 050 – Home Health Agency
- 170 – Physical Therapist
- 171 – Occupational Therapist
- 173 – Speech/Hearing Therapist

- 240 – Pharmacy

- 250 – Durable Medical Equipment (DME) Supply Dealer – Including pharmacies

- 251 – Home Medical Equipment (HME) Dealer – Including pharmacies

- 280 – Independent Laboratory

- 281 – Mobile Laboratory

- 282 – Independent Diagnostic Testing Facility (IDTF)

- 283 – Mobile Independent Diagnostic Testing Facility (IDTF)

- 290 – Free-Standing X-Ray Clinic

- 291 – Mobile X-Ray Clinic

- 300 – Freestanding Renal Dialysis Clinic

- 333 – Pathologist

Entering OPR Information on Claims

The following tables indicate the fields in which the ordering, prescribing, or referring provider's NPI must appear when it is required on a professional or institutional claim.

Table 11 – Entering OPR Information on a Professional Claim

Claim Submission Format	Form Field or Data Element
CMS-1500 claim form	Field 17b – Referring Provider or Other Source NPI
837P professional electronic data interchange (EDI) batch transaction	Loop 2310A – Referring Provider NM101 = P3 or DN NM109 = NPI
Provider Healthcare Portal – Professional claim	Referring Provider ID field

Table 12 – Entering OPR Information on an Institutional Claim

Claim Submission Format	Form Field or Data Element
UB-04 claim form	Field 78 – Other NPI *(if not already listed in fields 76 or 77)*
837I institutional EDI batch transaction	Loop 2310B – Operating Provider NM101 = 72, NM109 = NPI
	Loop 2310C – Other Operating Provider NM101 = ZZ, NM109 = NPI
Provider Healthcare Portal – Institutional claim	Operating Provider ID field
	Other Operating Provider ID field

Section 8: Claim Processing Overview

Claims for services provided to members of the Indiana Health Coverage Programs (IHCP) may be submitted for payment consideration on standardized paper claim forms or electronically, using 837 transactions or the Provider Healthcare Portal (Portal). The fee-for-service (FFS) claim processing procedures in this section apply to all IHCP claim types except pharmacy.

> *Note: Pharmacies submit drug claims at the point of sale (POS). The claims are adjudicated immediately, as long as all information is included and correct. Information about pharmacy claims is included in the [Pharmacy Services](#) module.*

Claim ID Number

IHCP claims are identified, tracked, and controlled using a unique 13-digit Claim ID assigned to each claim. The Claim ID numbering sequence identifies when the claim was received and the claim submission media used. This information assists providers with tracking claims, as well as tracking Remittance Advice (RA) or 835 transaction reconciliations.

> *Note: On the RA, the Claim ID is identified as **ICN** (internal control number).*

Table 13 describes the Claim ID format codes: R R, Y Y, J J J, and S S S S S S.

Table 13 – Claim ID Format

Code	Description
R R	These two digits refer to the region code or the submission source assigned to a particular type of claim. See the *[Region Codes](#)* section of this document for more information.
Y Y	These two digits refer to the calendar year the claim was received. For example, all claims received in calendar year 2020 would have 20 in this field.
J J J	These three digits refer to the Julian date the claim was received. Julian dates are shown on many calendars as days elapsed since January 1. There are 365 days in a year, 366 in a leap year. [Table 15](#) and [Table 16](#) display the Julian dates for a regular year and a leap year.
S S S S S S	The first three digits represent a systematically assigned sequence number. The next three digits refer to sequential numbering of a particular claim within a particular batch. Paper claim batches have a maximum of 100 individual claims within a batch; electronic claims have a maximum of 1,000 individual claims within a batch. > *Note: For the first claim in a batch, the final three sequence numbers are 000. For the last claim in a batch, the final three sequence numbers are 099 for paper claims or 999 for electronic claims.*

Region Codes

Table 14 describes region codes for specific claim types.

Table 14 – Region Codes

Code	Description
00	All claim regions
10	Paper claims with no attachments
11	Paper claims with attachments
20	Electronic claims (837 transaction) with no attachments
21	Electronic claims (837 transaction) with attachments
22	Internet claims (Provider Healthcare Portal) with no attachments
23	Internet claims (Provider Healthcare Portal) with attachments
24	Hoosier Healthwise managed care entity (MCE)-denied encounter claims
27	Healthy Indiana Plan (HIP) and Hoosier Care Connect MCE denied encounter claims
30	HIP encounter claims
32	HIP encounter replacements/voids
33	HIP encounter mass replacements
34	HIP reprocessed denied encounter claims
40	Fee-for-service (FFS) original claim converted from former Medicaid Management Information System (MMIS) to *Core*MMIS
41	Encounter original shadow claim converted from former MMIS
42	FFS original special projects region 90 claims converted from former MMIS
44	Encounter adjusted shadow claims converted from former MMIS
45	FFS adjusted claims converted from former MMIS
47	Encounter voided shadow claims converted from former MMIS
48	FFS voided claims converted from former MMIS
49	History only member link claims
50	Paper single replacement claim, noncheck or automatic audit agency noncheck (for partial replacement)
51	Replacement claims, check related (for paper or automatic audit agency, partial refund)
52	Mass replacements non-check-related
54	Stale dated check voids
55	Mass replacement, institutional provider retroactive rate
56	Mass void request or single claim void (paper or audit full recoupments)
57	Replacements – void check related (paper or audit full recoupments)
61	Provider replacement – Electronic with an attachment or claim note
62	Provider replacement – Electronic without an attachment or claim note
63	Provider-initiated electronic void
64	Waiver liability (formerly referred to as spend-down) or end-stage renal disease (ESRD) liability end of month (EOM) auto-initiated mass replacement
70	Encounter claims
72	Encounter claims replacements/voids
73	Encounter mass replacements
74	Reprocessed denied encounter claims

Code	Description
75	Nonemergency medical transportation (NEMT) encounter claim
76	NEMT encounter replacement
77	NEMT encounter void
78	NEMT encounter mass replacement
79	NEMT reprocessed denied encounter claims
80	Reprocessed denied claims
91	Special batch requiring manual review

Julian Dates

Julian dates and corresponding calendar dates for a regular year and a leap year are listed in Tables 15 and 16.

Table 15 – Julian Dates – Regular Year

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

Table 16 – Julian Dates – Leap Year

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

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Internal Control Number/Claim ID Examples

The following examples illustrate the ICN/Claim ID sequence on the RA:

- A dental claim submitted on the *ADA 2012* paper claim form with no attachments received on August 1, 2019, is assigned the ICN/Claim ID 1019213099000.
  - Digits 1 and 2 (10) – Region code (paper claim without attachments)
  - Digits 3 and 4 (19) – Year the claim was received (2019)
  - Digits 5−7 (213) – Julian date received (August 1)
  - Digits 8−10 (099) – Sequential numbers systematically assigned
  - Digits 11−13 (000) – Claim number systematically assigned within the batch (first in the batch)

- A professional claim submitted using the 837P electronic transaction, with no attachments, received on March 1, 2019, is assigned the ICN/Claim ID 2019060699215.
  - Digits 1 and 2 (20) – Region code (electronic claim [837 transaction] with no attachments)
  - Digits 3 and 4 (19) – Year the claim was received (2019)
  - Digits 5−7 (060) – Julian date received (March 1)
  - Digits 8−10 (699) – Sequential numbers systematically assigned
  - Digits 11−13 (215) – Claim number systematically assigned within the batch (216th)

- An outpatient claim submitted via the Portal, with attachments, received on June 16, 2020 (a leap year), is assigned the ICN/Claim ID 2320168147033.
  - Digits 1 and 2 (23) – Region code (Internet [Portal] claim with attachments)
  - Digits 3 and 4 (20) – Year the claim was received (2020)
  - Digits 5−7 (168) – Julian date received (June 16 in a leap year)
  - Digits 8−10 (147) – Sequential numbers systematically assigned
  - Digits 11−13 (033) – Claim number systematically assigned within the batch (34th)

Paper Claim Processing

A step-by-step review of paper claim processing, also known as manual or hard-copy claim processing, follows:

1. The provider completes claims according to the instructions in this module and mails them to the appropriate claim-processing address. Mailing addresses are found in the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.

2. The U.S. Postal Service delivers claims to DXC by routine mail, special delivery, overnight mail, or courier. Claims are assigned a Julian date that corresponds to the date of receipt.

3. The mailroom sorts claims by claim type with attachments or without attachments. Sending claims to the correct P.O. Box significantly speeds sorting time.

4. When a claim form is received for processing, specific form fields are reviewed and validated for completion. If it is determined that the fields are completed incorrectly or blank, the claim form and any attachments are returned to the provider, which prevents processing of the claim. The provider should review the reasons the claim was returned, make the appropriate corrections, and then resubmit the claim for processing consideration. Claims that are reviewed in the mailroom may be returned for the reasons listed in Table 17.

Table 17 – Claims Returned to Provider

Return To Provider (RTP) Letter Language	Explanation
Invalid NPI, taxonomy and/or ZIP Code+4.	For healthcare providers, the National Provider Identifier (NPI) is required and the taxonomy code is optional. Verify that the billing provider NPI is located in the correct field and entered in the proper format. The correct field for each claim form is as follows: <table><tr><td>*UB-04*</td><td>Form field 56</td></tr><tr><td>*CMS-1500*</td><td>Form field 33a</td></tr><tr><td>*ADA 2012*</td><td>Form field 49</td></tr></table>
Indiana Health Coverage Programs (IHCP) provider number is missing or invalid. Provider numbers consist of nine numeric characters and one alpha character, indicating the service location code.	Atypical providers bill with the IHCP Provider ID. <table><tr><td>*UB-04*</td><td>Form field 57C</td></tr><tr><td>*CMS-1500*</td><td>Form field 33b *Note: Qualifiers are:* *G2 = IHCP Provider ID* *Or* *ZZ = Taxonomy*</td></tr><tr><td>*ADA 2012*</td><td>Form field 50</td></tr></table>
Medicare information not submitted in field 22.	For crossover claims, the combined total of the Medicare coinsurance or copayment and deductible must be reported on the *left* side of field 22 under the heading *Resubmission Code* on the *CMS-1500* claim form. The Medicare paid amount (actual dollars received from Medicare) must be submitted on the *right* side of field 22 under the heading *Original Ref. No.*
Services were not submitted on an approved claim form. Submit the request for payment on the appropriate *CMS-1500* version 02/12, *UB-04*, or Dental Claim Form (*ADA version 2012*).	The IHCP accepts the *UB-04* institutional claim form, the *CMS-1500* professional claim form, the *ADA 2012* dental claim form, the National Council for Prescription Drug Programs *IHCP Drug Claim Form*, and the *IHCP Compounded Prescription Claim Form*.
Provider must submit Medicare information on the *UB-04* claim form in field 54A.	Use field 54A of the *UB-04* claim form to indicate the Medicare paid amount. Do not include the Medicare-allowed amount or contract adjustment amount in field 54.
Continuous paper claims are not accepted.	Only six detail lines are billable on a *CMS-1500* claim form. Only 10 detail lines are billable on an *ADA 2012* form. Continuous paper claims are not accepted for dental or professional claims. Each individual claim must have a total.

Return To Provider (RTP) Letter Language	Explanation
The maximum number of detail lines was exceeded for this claim form. Submit additional details on a separate claim form. The total billed amount on each claim form must equal the sum of the detail lines on each individual claim form.	A limited number of detail lines is allowed on each claim form: • The *CMS-1500* claim form allows a maximum of six detail lines. • The *ADA 2012* claim form allows a maximum of 10 detail lines. • The *UB-04* claim form allows a maximum of 66 detail lines (three-page continuation claim, with up to 22 detail lines per page).
The *UB-04* claim was submitted with a missing or invalid Type of Bill. Correct the Type of Bill field and resubmit claim.	The three-digit type-of-bill (TOB) code is required in field 4 of the *UB-04* claim form. The code must represent an appropriate type of bill for the claim being submitted. Valid TOB codes may be found on the NUBC website at nubc.org.
The ACN number is not at the top of the attachment(s).	The attachment control number (ACN) allows the IHCP to match the attachment to the submitted claim and must be written at the top of each page of the attachment.
Duplicate ACN was submitted for attachment. Must resubmit a new claim.	Each claim submitted with attachments must have a unique ACN.
The *Attachment Cover Sheet* has an invalid provider number or is missing a member identification number, or dates of service.	The *Attachment Cover Sheet* must be filled in completely.
Medicare Health Maintenance Organization (HMO) Replacement Plan paper claim completed incorrectly.	On crossover claims submitted to the IHCP, Medicare and Medicare Replacement Plan payment information should be indicated in field 22 of the *CMS-1500* form and fields 39–41 and 54 of the *UB-04* form. For professional (medical) and outpatient crossover claims, Medicare or Medicare Replacement Plan information is also required at the **detail** level. The *TPL/Medicare Special Attachment Form* must be used to submit this information with the paper claim. Denied line items must be submitted on separate claim forms from paid line items. When submitting a claim for Medicare or Medicare Replacement Plan denied detail lines, the explanation of benefits (EOB) must be attached.
The ICD version indicator is missing from the claim or the ICD version indicator is invalid. A valid ICD indicator is "9" for ICD-9 or "0" for ICD-10. Claims may not be submitted without an ICD version indicator.	Claims may not be submitted without an ICD version indicator of 0 (for ICD-10) or 9 (for ICD-9). ICD-10 codes should be used on all claims submitted with dates of service on or after October 1, 2015.

> *Note:* *Claims received without an NPI (or IHCP Provider ID, for atypical providers only), a provider name, and return address cannot be processed and cannot be returned. These claims are destroyed.*

1. Claims are grouped together; for example, all *CMS-1500* claims without attachments are sorted into batches of 100 and transferred to the scanning area.

2. All claims and attachments are scanned. During the scanning process, claims are assigned a specific Claim ID based on the claim type, region code, and receipt date. Claim attachments receive the same Claim ID as the claim.

3. Hard-copy batches are transferred to the data entry area, where the information is typed into the *Core*MMIS claim-processing system.

> *Note: Medical and dental batches are maintained in storage for 30 calendar days, and UB-04 batches are maintained in storage for 60 calendar days for potential review by claim examiners. After the storage limit has been reached, the hard-copy batches are destroyed, because claims are stored electronically.*

4. Claim data is stored in *Core*MMIS.

5. The claim is processed. *Core*MMIS claim processing has three possible results:
    –   All claim data complies with the correct format and IHCP policy rules and results in a paid claim.
    –   Claim data does not comply with the correct format or IHCP policy rules and results in a denied claim.
    –   A claim examiner must review a particular aspect of the claim because the claim is suspended. For example, a sterilization procedure suspends a claim for review of the required sterilization consent form. A claim examiner approves the claim for payment, if appropriate, and if the correct information was sent with the claim. Otherwise, the claim is denied. Suspended claim resolution is discussed in more detail in the *Section 9: Suspended Claim Resolution* section of this document.

Weekly, *Core*MMIS generates an RA that contains the status of each processed claim:

*   The electronic RA in the 835 format contains paid and denied claims.

*   The Portal RA lists paid, denied, in process, on hold, and adjusted claims.

*   Adjusted claims show one time on the RA when they are paid or denied.

Remittance Advice information is presented in the *Financial Transactions and Remittance Advice* module.

Provider Healthcare Portal Claim Processing

A step-by-step review of claim processing for claims submitted via the Portal follows:

1. The provider enters claim data in the Portal according to the instructions in this module and the online system Help features. The Portal conducts limited validity editing during the claim-entry process to help ensure adherence to IHCP policies and procedures and national coding guidelines.

2. When the claim is submitted, the Portal automatically assigns it a Claim ID.

3. Data entered into the Portal is automatically transferred to *Core*MMIS.

4. If the claim indicates that attachments are being sent by mail (rather than uploaded to the Portal):
    –   The U.S. Postal Service delivers attachments to the DXC mailroom by routine mail, special delivery, overnight mail, or courier, or attachments can be hand delivered. Attachments are assigned a Julian date that corresponds to the date of arrival in the mailroom.
    –   Staff members briefly review the attachments for completeness and accuracy of the number of ACNs to the number of attachments. If errors are found, the cover sheets and attachments are returned to the provider for correction and resubmission.
    –   Batches are transferred to the data entry area, and data entry analysts enter the ACNs into the claim- processing system.

5. The claim and attachments are reviewed for accuracy, completeness, and validity before it is approved, denied, or suspended/pended for additional review.

6. The status of the claim is updated in the Portal. The status will show as "Finalized Denied," "Finalized Payment," or "Pending in Process."

7. Additional claim information, such as Remittance Advice, is updated in the Portal as it becomes available.

837 Electronic Transaction Claim Processing

A step-by-step review of claim processing for claims submitted via 837 electronic transaction follows:

1. The trading partner creates claim data files according to the instructions in this document, the *IHCP Companion Guides*, and the *837 Implementation Guides*. The data is transmitted electronically to DXC, using secure file transfer protocols and in accordance with the specifications of hardware and software systems. An intermediary can also be involved in transmitting electronic claims.

2. DXC receives electronic claims from multiple transmission sources, 24 hours a day, 7 days a week. When claims are received, the files are immediately sorted by claim type, such as 837I (institutional), 837D (dental), or 837P (professional) electronic claims.
   – Claims that do not pass *Health Insurance Portability and Accountability Act* (HIPAA) compliance standards are rejected during pre-cycle editing.
   – A 999 Functional Acknowledgement response transaction reports on the acceptance or rejection status of claims and is posted for trading partners to retrieve.
   – A TA1 Interchange Acknowledgement is returned to the trading partner if the entire file fails due to enveloping errors in the file.
   – Claims that are rejected do not enter the *Core*MMIS system and must be corrected and resubmitted by the trading partner.

3. Accepted claims are transferred to *Core*MMIS, a Claim ID is assigned, and pre-edit functions are performed.

4. For electronic claims with paper attachments:
   – The U.S. Postal Service delivers attachments to the DXC mailroom by routine mail, special delivery, overnight mail, or courier, or attachments can be hand delivered. Attachments are assigned a Julian date that corresponds to the date of arrival in the mailroom.
   – Staff members briefly review the attachments for completeness and accuracy of the number of ACNs to the number of attachments. If errors are found, the cover sheets and attachments are returned to the provider for correction and resubmission.
   – Batches are transferred to the data entry area, and data entry analysts enter the ACNs into the claim-processing system.

5. *Core*MMIS processes these claims.

Section 9: Suspended Claim Resolution

Edits and audits are designed to monitor and enforce federal and state laws, regulations, and program requirements.

During the claim-adjudication process, claims that fail an edit or audit do one of the following:

- Systematically deny

- Systematically cut back or reduce the number of units billed on the claim

- Suspend

When a claim suspends, processing is suspended until the error causing the failure is reviewed, corrected, or otherwise resolved.

The process of reviewing, correcting, and resolving claim errors is performed in multiple areas, including the following: the Claims Resolution Unit and the Adjustment Unit at DXC, the medical policy department of the prior authorization (PA) contractor, and the Family and Social Services Administration (FSSA) Program Integrity team. The examiners in these organizations follow written guidelines in adjudicating claims that fail defined edits or audits.

Suspended Claim Location

Claim data that fails edits and audits (suspend disposition) is routed to a suspense location within the claim-processing system. Depending on the edit or audit that caused the failure, claims are routed to a specific claim location that identifies the type of edit or audit failed. These location codes are assigned to specific departments within DXC or the Indiana Health Coverage Programs (IHCP) PA contractor.

- Adjustments that fail any edit or audit are routed to the DXC Adjustment Unit or the appropriate medical policy department.

- Medical policy edit and audit failures are routed to the medical policy department of the PA contractor.

- Prepayment provider review edits are routed to Prepayment Review (PPR) staff within the FSSA Program Integrity team.

- The remaining edit and audit failures are routed to the DXC Claims Resolution Unit.

Suspended Claim Processing

*Core*MMIS distributes claims in suspense to the appropriate resolution examiner, distributing the oldest suspended claim to the examiner first. This process ensures that older claims are processed first. Suspended claims, along with the error codes and descriptions, are displayed to the examiners in a format similar to the claim form. The screen provides examiners with a field to apply claim-processing transactions, claim location for routing, or explanation of benefits (EOB) messages for claim denials. The screen allows examiners to access various reference files necessary to effectively process suspended claims.

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Examiners have the option of applying the following transactions when processing suspended claims, depending on the edit or audit failure:

- ADD/CHANGE – The examiners can correct typing errors. Examiners cannot change reimbursement data except in the case of manual pricing.

- FORCE/OVERRIDE – The edits and audits are overridden to force the claim to go through the claim-processing cycle regardless of the presence of the overridden error.

- DENY – The claim can be denied if called for by the edit or audit.

- ROUTE – The claim may be routed to a different claim location.

- RESUBMIT – The claim can be resubmitted. This action is applied if the claim failed an edit or audit that was set in error and has since been corrected. When resubmitted, the claim goes through the same processing procedures.

Suspended claims display all the error codes that caused the claims to suspend, up to a maximum of 20 error codes. The process follows:

1. The examiner clears all the error codes applicable to the claim location.

2. The claim is routed to the next applicable location if there are other errors that require correction.

3. The claim is resubmitted for processing and is again subjected to all the edits and audits.

Overrides applied to any errors are captured to prevent the claim from suspending again for the same error. These overrides stay with the claim record history.

Suspended Claim Guidelines for Processing

DXC must adjudicate clean paper claims within 30 calendar days of receipt. Clean electronic claims must be adjudicated within 21 calendar days of receipt. These guidelines apply to all claims, even those that suspend for review. The exceptions to the guidelines are as follows:

- Claims suspended for medical review

- Claims submitted by a provider subject to prepayment review

Paper claims that are not adjudicated within 30 days and electronic claims that are not adjudicated within 21 days are subject to interest accrual, as described in *Indiana Code IC 12-15-21-3(7)(A)*.

Electronic claims followed by attachments must contain the provider-assigned attachment control numbers (ACNs) corresponding to the ACNs on the attachment cover sheet and the pages of each attachment to match with the claim for review.

For members eligible for both Medicare and Medicaid (called *dually eligible* members), claims for which Medicare or a Medicare Replacement Plan has previously made payment (including payments of zero due to a deductible, coinsurance, or copayment), are called *crossover claims*. This section describes claim submission and processing procedures for crossover claims.

More information about Medicare and Medicare Replacement Plan crossover claims is located in the *Third-Party Liability* module and *Section 5: Coordination of Benefits*. For information about Medicare exhaust claims (billing the IHCP when a dually eligible member's Medicare benefits are exhausted prior to or during an inpatient stay), see the *Inpatient Hospital Services* module.

Reimbursement Methodology for Crossover Claims

The Indiana Health Coverage Programs (IHCP) reimburses covered services for Medicare and Medicare Replacement Plan crossover claims only when the Medicaid-allowed amount exceeds the amount paid by Medicare. When the Medicare-paid amount exceeds the Medicaid-allowed amount, claims are processed with a paid claim status with a zero reimbursed amount.

If the Medicaid-allowed amount exceeds the Medicare-paid amount, the IHCP reimburses using the lesser of the Medicare coinsurance or copayment plus deductibles, or the difference between the Medicaid-allowed amount and the Medicare-paid amount. The reimbursement also reflects any other third-party liability (TPL) payments and Medicaid waiver and patient liability amounts. The following formulas represent how payment for crossover claims is calculated:

- Institutional crossover claims:

  (Medicare Deductible + Coinsurance or Copayment + Blood Deductible) – (TPL Payments + Medicaid Waiver Liability + Patient Liability [Nursing Homes Only]) = Reimbursement Amount

- Professional crossover claims:

  (Medicare Deductible + Coinsurance or Copayment) – (Medicaid Waiver Liability + TPL Payments) = Reimbursement Amount

Automatic Crossovers

Claims that meet certain criteria cross over automatically from Medicare and are reflected on the IHCP Remittance Advice (RA) statement or 835 transaction. Wisconsin Physician Services (WPS) is the contractor for Coordination of Benefits Agreement (COBA). The basic criteria follow:

- Medicare makes a payment for the billed services.

- WPS validates against the member file submitted by Indiana Medicaid and submits claims based on the member information. WPS is set up as a trading partner and approved to transmit claims data to DXC.

- *Core*MMIS has all Medicare codes on file. If the Medicaid allowed amount for the services billed exceeds the Medicare paid amount for the services, Traditional Medicaid pays the lesser of the coinsurance or copayment plus deductible amounts, or the difference between the Medicaid-allowed amount and Medicare-paid amount.

- There is no Traditional Medicaid filing time limit for paid crossover claims from Medicare or a Medicare Replacement Plan.

Electronic crossover claims are received in batch 837 files from WPS.

Claims That Do Not Cross Over Automatically

Medicare and Medicare Replacement Plan crossover claims that do not automatically cross over to Medicaid from WPS must be submitted by the provider to DXC for adjudication. They can be submitted electronically using the IHCP Provider Healthcare Portal (Portal) or the 837 transaction, or by mail using the appropriate paper claim form. Payment information from Medicare and any other payer must be included on the claim. For professional (medical) and outpatient crossover claims (IHCP claims where Medicare or a Medicare Replacement Plan made payment, including payments of zero) submitted on paper claim forms, providers must also include an *IHCP TPL/Medicare Special Attachment Form* for reporting the primary insurer information at the detail level. For Portal claims and 837 transactions, this detail-level Medicare information is submitted within the electronic claim itself. See *Section 5: Coordination of Benefits* for specific billing instructions and requirements.

> Note: *Ambulatory surgical centers (ASCs) that bill Medicare on a CMS-1500 claim form or 837P transaction must use an institutional claim (UB-04 or electronic equivalent) to bill the IHCP if the claim does not cross over automatically. Similarly, long-term care (LTC) facilities must use the institutional claim to submit Medicare charges for parenteral and enteral services and therapies to the IHCP.*
>
> *FQHCs and RHCs that bill Medicare on the UB-04 or 837I transaction must use a professional claim (CMS-1500 or electronic equivalent) to bill the IHCP if the claim does not cross over automatically.*

If a provider does not receive the IHCP payment within 60 days of the Medicare payment and has no record of the claim crossing over automatically, the claim should be submitted to the IHCP according to the instructions in this section.

A claim may not automatically cross over for the following reasons:

- The Medicare carrier or intermediary is not WPS or is not a carrier that has a partnership agreement with DXC.

- The IHCP provider file does not reflect the Medicare provider number. For all crossover claims, the provider's National Provider Identifier (NPI) must be on file with the IHCP. The *Provider Enrollment* module provides additional information.

- The provider is not a Medicare provider and does not accept assignment to bill the IHCP for dual eligible members.

- Medicare does not reimburse the claim. Medicare denies payment because the service is not covered or does not meet the Medicare medical necessity criteria.

To ensure appropriate processing of crossover claims submitted directly to the IHCP, providers must not bill Medicare denied services on the same claim with Medicare paid services. Providers must split the claim and group all denied line items on one claim form or electronic claim transaction, and all paid line items on another (as a crossover claim). When submitting the claim for Medicare or Medicare Replacement Plan denied services, it is critical that providers attach a copy of the EOB or EOMB, as described in the *Medicare and Medicare Replacement Plan Denials* section.

> Note: *The 180-day filing limit does not apply to crossover claims where Medicare or the Medicare Replacement Plan made a payment (including zero-paid claims) and Traditional Medicaid is paying the coinsurance and deductible amount. If Medicare or a Medicare Replacement Plan denies the claim, the 180-day filing limit applies to the Traditional Medicaid claim. See *Section 11: Claim Filing Limits* for more information.*

For crossover claims submitted by mail:

- Send paper *UB-04* claim forms, including attachments, to the following address for processing:

  DXC – Institutional Crossover Claims
  P.O. Box 7271
  Indianapolis, IN 46207-7271

- Send paper *CMS-1500* claim forms, including attachments, to the following address for processing:

  DXC – CMS-1500 Crossover Claims
  P.O. Box 7267
  Indianapolis, IN 46207-7267

For claims submitted electronically using an 837 transaction, attachments must be sent by mail according to the instructions in the *Mailing Paper Attachments for Electronic Claims* section. If submitting claims via the Portal, providers have the option to upload and submit the attachments electronically along with the claim.

Using the UB-04 Claim Form to Submit Claims That Did Not Cross Over Automatically

The following billing instructions help ensure accurate processing of all *UB-04* Medicare or Medicare Replacement Plan crossover claims:

- Use fields 39a–41d to identify information from the Medicare EOMB or Medicare Replacement Plan EOB. These fields are required, if applicable. The following value codes must be used, along with the appropriate dollar or unit amounts for each:
  - Value code A1 – Medicare or Medicare Replacement Plan deductible amount
  - Value code A2 – Medicare or Medicare Replacement Plan coinsurance or copayment amount
  - Value code 06 – Medicare or Medicare Replacement Plan blood deductible amount

  Use a value code of 80 to reflect IHCP-covered days.

Figure 70 – Example of Completing Value Codes Fields on the *UB-04* Claim Form

- In fields 50–54, use row A to reflect Medicare or Medicare Replacement Plan information only. Use field 54A to indicate the Medicare or Medicare Replacement Plan paid amount, meaning the actual dollars received from Medicare. Do not include the Medicare or Medicare Replacement Plan allowed amount or contractual adjustment amount in field 54A.
  - If the Medicare paid amount is greater than the billed amount, indicate the correct dollar values in the fields. Then, in field 55C, reflect the estimated amount due as $0. This amount does not have a negative impact on the payment of a crossover claim.
  - If the Medicare paid amount (field 54A) is zero due to a claim denial by the primary insurer, the Medicare EOMB or Medicare Replacement Plan EOB must be attached to the IHCP claim.

Figure 71 – Example of Completing Fields 50A, 51A, and 54A on the *UB-04* Claim Form

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	Medicare	999999999			350.00	
B						
C						

- In fields 50–54, row B is reserved for commercial insurance carrier information. Use field 54B to denote any commercial insurance carrier or third-party liability payment information.

- Leave fields 55A and 55B blank. Use field 55C to reflect the amount calculated in the following equation:

  Total claim amount – (Medicare or Medicare Replacement Plan paid [54A] + Medicare supplement or third-party liability [54B]) = Estimated Amount Due (55C)

  – Automated spend-down outpatient hospital claims that span more than 1 month are credited to spend-down based on individual dates of services, as reported on the detail lines of the claim.

> *Note: The amount in form field 55C is not necessarily equal to the coinsurance and deductible amounts present on the EOMB, but is calculated using the correct data for each of the fields.*

- Outpatient crossover claims also require Medicare payment information to be reported at the detail level. Providers must submit the *IHCP TPL/Medicare Special Attachment Form* to supplement information submitted on the paper claim form. Providers should include Medicare payment amounts and any deductible, coinsurance, copayment, and blood deductible for each detail. Instructions for completing the form, as well as the form itself, are available on the *Forms* page at in.gov/medicaid/providers.

Figure 72 – Example of Completing Associated Fields on the
IHCP TPL/Medicare Special Attachment Form

3. List other payers in order of responsibility. 1- Primary, 2 – Secondary, 3 - Tertiary

Seq	Health Plan ID	Payer Name and Address	Policy Number	Date Paid
1	999999999	Medicare	888888888	01/01/2017
2				
3				

4. Enter prior payment amounts per claim detail.

Detail #	Payer Seq	Deductible PR 1	Coinsurance PR 2	Copayment PR3	Blood Ded PR 66	Psych Red PR 122	Amount Paid	ARC Required if Amount Paid = 0
1	1	25.00					250.00	
2	1	15.00					100.00	

Using the CMS-1500 Claim Form to Submit Claims That Did Not Cross Over Automatically

For Medicare and Medicare Replacement Plan crossover claims submitted on the *CMS-1500* claim form, providers must adhere to the following instructions:

- Enter the combined total of the Medicare coinsurance or copayment and deductible in the left side of field 22, under the heading *Resubmission Code*.

- Enter the Medicare paid amount, meaning the actual dollars received from Medicare or Medicare Replacement Plan, in the right side of field 22, under the heading *Original Ref. No.*
  - If the Medicare paid amount (field 22) is zero due to a denial by the primary insurer, providers must attach the Medicare EOMB or Medicare Replacement Plan EOB to the IHCP claim.

- Itemize the Medicare paid amounts for each detail, as well as the detail-level deductible, coinsurance, copayment, and blood deductible, as applicable, on the *IHCP TPL/Medicare Special Attachment Form*. Complete instructions for completing the *IHCP TPL/Medicare Special Attachment Form* are on the *Forms* page at in.gov/medicaid/providers.

Figure 73 – Example for Completing Field 22 of the *CMS-1500* Claim Form

22. RESUBMISSION CODE	ORIGINAL REF. NO.
35.00	350.00

Figure 74 – Example for Completing Associated Fields on the *IHCP TPL/ Medicare Special Attachment Form*

3. List other payers in order of responsibility. 1- Primary, 2 – Secondary, 3 - Tertiary

Seq	Health Plan ID	Payer Name and Address	Policy Number	Date Paid
1	9999999999	Medicare	8888888888	01/01/2017
2				
3				

4. Enter prior payment amounts per claim detail.

Detail #	Payer Seq	Deductible PR 1	Coinsurance PR 2	Copayment PR3	Blood Ded PR 66	Psych Red PR 122	Amount Paid	ARC Required if Amount Paid = 0
1	1	25.00					250.00	
2	1	15.00					100.00	

Using the Portal to Submit Claims That Did Not Cross Over Automatically

When submitting Medicare or Medicare Replacement Plan crossover claims for professional or institutional services via the Portal, providers must include information regarding the payment amount, coinsurance or copayment, and/or deductibles as follows:

1. During Step 1 of the claim submission process, select the **Include Other Insurance** box.

2. During Step 2 of the claim submission process, complete the following fields in the *Other Insurance Details* panel (see Figure 75):
   - In the Carrier Name field, enter "Medicare" or the name of the Medicare Replacement Plan.
   - In the Carrier ID field, enter the appropriate Medicare or Medicare Replacement Plan identification number.
   - Complete the Policy Holder Last Name, First Name, Policy ID, and Relationship to Patient fields.
   - In the Claim Filing Code field, select the appropriate option:
     - 16 – Health Maintenance Organization (HMO) Medicare Risk
     - MA – Medicare Part A
     - MB – Medicare Part B
   - In the TPL/Medicare Paid Amount field, enter the paid amount for the entire claim.

Figure 75 – Adding Other Insurance Details Panel

3. Click **Add** to append this carrier to the Other Insurance Details table.

4. Click the Medicare or Medicare Replacement Plan's hyperlinked number in the # column of the Other Insurance Details table.

5. Enter the Claim Adjustment Group Code, Reason Code, and Adjustment Amount information in the *Claim Adjustment Details* panel (see Figure 76) and then click **Add.**

Figure 76 – Claim Adjustment Details Panel

6. Click **Save**.

7. Continue completing the claim, including adding service details.

> *Note: For professional and outpatient crossover claims, follow steps 8–14 to add Medicare and other TPL information at the service detail level.*

8. After adding a service detail, click the hyperlinked number for that detail in the # column of the Service Details table to access the *Other Insurance for Service Details* panel.

9. Select the Medicare or Medicare Replacement Plan (added in Step 2) from the Other Carrier drop-down menu and complete the TPL/Medicare Paid Amount and Paid Date fields for the service detail.

10. Click **Add** to save the other insurance information for that service detail.

11. Click the hyperlinked number for the service detail once again to access the Other Insurance for Service Details table, and then click the hyperlinked number for the Medicare or Medicare Replacement Plan carrier to access the *Claim Adjustment Details* panel.

12. In the *Other Insurance for Service Details* panel, click the hyperlinked number in the # column to access the *Claim Adjustment Details* panel for that carrier.

13. Enter the Claim Adjustment Group Code, Reason Code, and Adjustment Amount information for the service detail selected and then click **Add.**

14. Repeat steps 8–13 for all service details, and then click **Save** and proceed with the claim submission process.

> *Note: If the Medicare paid amount entered in step 2 is zero due to a denial by the primary carrier, the Medicare EOMB or Medicare Replacement Plan EOB must be attached.*

Coordination of Benefits Denials for Crossover Claims

The following sections describe IHCP claim denials related to Medicare coordination of benefits (COB) information.

Inpatient and Long-Term Care Crossover Claims

For Medicare and Medicare Replacement Plan inpatient and LTC crossover claims, providers must report COB adjustment information at the header level. If no COB adjustment information is present on the claim, the claim will be denied with EOB 2500 – *This member is covered by Medicare Part A; therefore, you must first file claims with Medicare.*

Professional and Outpatient Crossover Claims

For Medicare and Medicare Replacement Plan professional and outpatient crossover claims, providers must report COB adjustment information at the header **and** detail level. If no COB adjustment information is present at the detail level, the claim will be denied with EOB 2502 – *This member is covered by Medicare Part B or Medicare D; therefore, you must first file claims with Medicare. If already submitted to Medicare, please submit your EOMB.*

Medicare-Denied Details on Crossover Claims

Medicare-denied details on crossover claims deny with EOB 593 – *At least one detail submitted contains Medicare COB data resulting in a review of all detail COB data. Please review to ensure COB data for detail in question does not contain all zeros or is missing.* This EOB posts when the calculated detail allowed amount is equal to zero and there is no coinsurance, deductible, or copayment.

Medicare and Medicare Replacement Plan Denials

Note that Medicare-denied services are not crossover services. Medicare-denied services must be filed with the IHCP on a separate claim form or electronic claim submission from Medicare-paid services.

If a claim has been denied by Medicare, the EOMB must be attached to the claim. If a claim has been denied by a Medicare Replacement Plan, the Medicare Replacement Plan EOB must be attached to the claim with **"Medicare Replacement Plan"** written on the top of the attachment.

For claims submitted via the Portal, the attachment may be uploaded and submitted electronically, along with the claim. To submit the attachment by mail when the claim is sent electronically, see the *Mailing Paper Attachments for Electronic Claims* section of this module.

Providers must submit claims to the Indiana Health Coverage Programs (IHCP) within 180 calendar days of the date the service was rendered. For inpatient claims, the 180-day limit is based on the member's date of discharge. See the *Indiana Administrative Code 405 IAC 1-1-3* for the complete rule narrative about filing limits.

All claims must be filed, resubmitted, adjusted, or replaced using the regular submission methods and the appropriate addresses. The *IHCP Quick Reference Guide* at in.gov/medicaid/providers contains the most current claim filing addresses. As a rule, Written Correspondence staff, Customer Assistance representatives, and Provider Relations field consultants do not file claims on a provider's behalf. Claims mailed to addresses other than those noted in the *IHCP Quick Reference Guide* will be returned to the provider for filing through normal channels, unless otherwise instructed. Any resulting processing delays could negatively affect compliance with timely filing limits.

In some instances, claims filed beyond the 180-day filing limit can be considered for reimbursement if the proper supporting documentation is submitted with the claim. It is important to note that each claim stands on its own merit, which means that each claim must have a set of supporting documentation attached. Submitting multiple claims with only one set of documentation is not acceptable.

Timely Filing Limit Exceptions

This section presents exceptions to the 180-day timely filing limit.

When Timely Filing Limit Is Not Applicable

The 180-day timely filing limit **is not applicable** in the following circumstances:

- **Crossover claims** − Medicare or Medicare Replacement Plan primary claims containing paid services (including services that paid at zero, due to deductibles) are not subject to the 180-day timely filing limit.

  > *Note: If Medicare or a Medicare Replacement Plan **denies** a claim, the 180-day limit applies to the Medicaid claim.*

- **Overpayment adjustment requests** − These requests are not subject to the 180-day timely filing limit. Any overpayment identified by a provider must be returned to the IHCP regardless of the 180-day filing limit. The overpayment adjustment must be submitted with an explanation attached to justify partial recoupment; otherwise the claim will be processed and recouped in its entirety.

When Timely Filing Limit Is Extended

The 180-day timely filing limit **is extended** in the following circumstances:

- If a member's eligibility is effective retroactively, the timely filing limit is *extended to 180 days from the date eligibility was established.* Documentation must be submitted with the claim identifying retroactive eligibility.

- If prior authorization (PA) for a service is approved retroactively, the timely filing limit is *extended to 180 days from the date the PA was approved*. A copy of the approved PA stating "retroactive prior authorization" must be included as an attachment to the claim.

- If an IHCP policy change is effective retroactively, the timely filing limit is *extended to 180 days from the date of publication of the policy change*. A copy of the publication must be included as an attachment to the claim.

- For waiver providers, proof that a plan of care was issued late or copies of the review findings letter from an audit must be submitted.

- If third-party payer notification is delayed, the timely filing limit is *extended to 180 days from the date on the explanation of benefits (EOB) from a primary payer.* A copy of the primary payer's EOB must be included as an attachment to the claim.

When Extenuating Circumstances Are Considered for Waiving the Timely Filing Limit

For the situations listed in this section, the Family and Social Services Administration (FSSA) will review and determine if the documentation substantiates override of timely filing. These situations will be considered on an individual basis. The 180-day timely filing limit **will be waived** if justification is provided to substantiate the following circumstances:

- Lack of timely filing is due to an error or action by DXC, OptumRx, the State, or county – The claim must be submitted with documentation that clearly identifies the error or action that delayed proper adjudication of the claim.

- Reasonable and continuous unsuccessful attempts by the provider to receive payment from a third party, such as Medicare or another insurance carrier – The claim must be submitted with documentation that clearly identifies multiple filing attempts in a timely manner along with all responses from the payer or third party.

> *Note: If a third-party payer fails to respond, the provider must indicate **"No response after 90 Days"** on an attachment. Detailed information for submission using the 90-Day provision is located in the [Third-Party Liability](#) module.*

- Reasonable and continuous unsuccessful attempts by the provider to resolve a claim problem – The claim must be submitted with documentation that clearly identifies multiple filing attempts to **correct and resolve** claim problems in a timely manner along with all responses. Resubmitting the claim without any corrections does not constitute a filing attempt.

How to Submit Claims for Filing Limit Waiver Requests

The following documents may be included in documentation showing that reasonable and continuous attempts have been made to correct and resolve claim problems:

- Remittance Advice (RA) statements

- 277 Claim Inquiry response transaction from the 276 Claim Inquiry transaction

- Claim screen print from the IHCP Provider Healthcare Portal (Portal)

- Answered inquiries (submitted via mail or Portal secure correspondence) from the Written Correspondence Unit

- Dated EOBs from third-party payers

- IHCP-generated documentation of prior claim submission

- Letters from the local county office

- Letters from other insurance carriers

- Returned PA requests; a chronological narrative is also helpful

> *Note:*   *The timely filing limit cannot be waived without documentation; claims without the*
> *acceptable documentation will automatically deny for timely filing.* **Provider-**
> **generated notes or claims filing time lines are not acceptable documentation.**

Paper attachments should follow these guidelines:

- Legible and signed paper claims; photocopies acceptable

- Required supporting documentation; photocopies acceptable

- Documentation attached in chronological order; a chronological narrative is also helpful

- Individual documentation trail attached to each claim

- Correct address for claim attachments

> *Note:*   ***For providers using copies of claims for attachments****: When sending copies of paper*
> *claims as attachments, the provider must place a large* ***X*** *through the claim copy to*
> *indicate to the processor that the claim copy is being used for filing-limit*
> *documentation only.*

Situations That Will Be Reviewed on an Individual Basis by the FSSA

The following circumstances will be reviewed on an individual basis by the FSSA to determine if good faith efforts were made to prevent retroactive enrollment or submit claims in a timely manner:

- A member who is not eligible for the IHCP sees a provider that is not an IHCP provider. If the member is retroactively enrolled, the provider may also be retroactively enrolled and allowed to bill for services rendered.

- The provider is unaware that the patient was eligible for Medicaid at the time services were rendered. The following conditions must be met:
  - The provider's records document that the patient refused or was physically unable to provide his or her Medicaid number.
  - The provider can substantiate that reimbursement was continually pursued from the patient until Medicaid eligibility was discovered.
  - The provider billed the IHCP or otherwise contacted the IHCP in writing regarding the situation within 60 days of the date Medicaid eligibility was discovered [see *405 IAC 1-1-3(c)*].

- A member receives a service by an out-of-state provider that was not enrolled with the IHCP at the time services were rendered. Such situations will be reviewed on an individual basis by the FSSA to ascertain if the provider made a good-faith effort to enroll and submit claims in a timely manner.

Filing Limits for Claim Resubmissions, Adjustments, and Requests for Administrative Review

If an initial claim **is filed timely and is denied**, the provider has the following options:

- If a claim denial is due to a provider's incorrect or inaccurate claim information, the provider may resubmit the claim with corrections. For adjudication purposes, a denied claim that is resubmitted *with corrected information* is considered to be an *initial* claim and, as such, is subject to the 180-day timely filing limit. For adjudication purposes, a denied claim resubmitted *without corrected information* is considered to be a *duplicate* claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the 180-day timely filing limit and will not

be accepted as "*reasonable and continuous attempts to resolve a claim problem*" for consideration to waive or extend the timely filing limit.

- If a claim denial is not due to a provider's incorrect or inaccurate claim information, but the provider disagrees with the denial, the provider may submit a written request for an administrative review stating why the provider disagrees with the claim denial. The written request for administrative review must be filed within 60 days of notification of the claim's disposition. The date of notification is considered to be the date on the RA.

If a line item on a claim is denied, that line item should be resubmitted separately, unless the claim details are dependent of one another for payment. For example; all surgical services for the same member, same date, and same provider must be submitted on one claim form and cannot be separately processed. To rebill a surgical procedure, a claim adjustment must be requested.

If an initial claim **is filed timely and is paid**, including claims partially paid, or paid at zero, the provider has the following options:

- If a claim paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider may submit a claim adjustment via paper or a *claim void/replacement* electronically with corrections. The claim adjustment or claim void/replacement must be filed within 60 days of notification of the claim's disposition. The date of notification is considered to be the date on the RA.

- If a claim payment disagreement is not due to a provider's error, the provider may submit a written request for administrative review stating why the provider disagrees with the claim payment amount. The written request for administrative review must be filed within 60 days of notification of the claim's disposition. The date of notification is considered to be the date on the RA.

Denied claims are not eligible for adjustment or void and replacement processes. See previous section for procedures for denied claims.

See the *Claim Adjustments* module and the *Claim Administrative Review and Appeals* module for detailed information.