INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER BULLETIN

BT200703 JANUARY 30, 2007

To: All Providers

Subject: Updated CMS-1500 Paper Claim Form Requirements

The following information does not apply to providers rendering services in the risk based managed care (RBMC) delivery system. These providers should contact the managed care organization (MCO) with whom they are contracted for information about paper claim form transition.

Overview

Centers for Medicare & Medicaid Services (CMS), through recommendations of the National Uniform Claim Committee (NUCC), is mandating that providers use revised paper claim forms. The Indiana Health Coverage Programs (IHCP) will discontinue acceptance of the current (12/90) versions of the CMS-1500 claim form effective April 1, 2007. Beginning April 1, 2007, only the revised CMS-1500, version 08-05, claim form will be accepted. Paper claims submitted on the old form will not be processed after March 31, 2007, and will be returned to the provider.

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

Table 1 – Timeline Revised Paper Claim Forms

Current Form	New Form	Transition Period (Old and New Forms Accepted)		Only New Forms Accepted (Cutover Date)
		Start Date	End Date	
CMS-1500 (12/90)	CMS-1500 (08-05)	February 15, 2007	March 31, 2007	April 1, 2007

Note 1: The new claim form includes fields for the National Provider Identifier (NPI) and National Drug Codes (NDC). The NDC implementation date is July 1, 2007. NDC information for Healthcare Common Procedure Coding System (HCPCS)-coded claims involving drugs will not be processed prior to that date.

Note 2: The NPI implementation date is May 23, 2007. During the transition period, billing providers who have been assigned an NPI should include both their NPI and their IHCP provider number (legacy provider number or LPI) on the paper claim form. Providers must remember to report the NPI assigned by the National Plan and Provider Enumeration System (NPPES) to IHCP Provider Enrollment before submitting claims using their NPI. Claims received after May 22, 2007 with NPI numbers that have not been reported to the IHCP will be returned to the provider.

CMS-1500 Paper Claim Form Changes and Requirements

This section provides a brief overview of the changes required for completion of the revised CMS-1500 claim form. The current CMS-1500 (12/90) version of the claim form will no longer be accepted after March 31, 2007.

The instructions outlined in this bulletin are effective for paper claim submissions starting February 15, 2007. Paper claims submitted beginning April 1, 2007, must meet the new claim form requirements. Beginning April 1, 2007, non-compliant paper claims submitted for processing will be returned to the provider. During the transition period, the IHCP will accept both the old and the new claim forms. During the transition, providers who have been assigned an NPI should include both their NPI and their IHCP provider number (LPI) on the paper claim form.

Reporting the NPI Using the NPI Reporting Tool

All providers required to report an NPI when submitting claims must first report the NPI and Taxonomy code(s) via the NPI Reporting Tool available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/NPITool/npi_logon.aspx or by using the *NPI Reporting Form* available on the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. Providers must use the taxonomy codes reported. The *National Provider Identifier (NPI)* page, located at http://www.indianamedicaid.com/ihcp/ProviderServices/npi.asp, contains information about the *IHCP NPI Implementation Plan* and instructions for obtaining an NPI.

Definitions

atypical provider	Atypical providers are providers that do not provide health care, as defined under Health Information Portability and Accountability Act (HIPAA) in Federal regulations at *45 CFR 160.103*. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the IHCP program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and therefore cannot receive an NPI. Therefore, the Medicaid Management Information System (MMIS) must be prepared to accommodate the current LPIs for atypical providers. For additional information refer to the CMS Web site at http://www.cms.hhs.gov/HIPAAGenInfo/06_AreYouaCoveredEntity.asp.
legacy provider identifier (LPI)	The provider number issued by the IHCP.
National Provider Identifier (NPI)	New identifier issued through the NPPES developed by CMS. NPI will replace most IHCP provider numbers (LPIs) currently used for billing purposes.
qualifier	Identifies what the value to the immediate right on the claim represents. 1D = Medicaid provider number (LPI) ZZ = Provider taxonomy
taxonomy number	National code identifying a provider type and specialty.

CMS-1500 Claim Form Fields

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

The CMS-1500 Claim Form Locator Descriptions (Table 2) uses **bold** type to indicate if a field is **Required** or **Required, if applicable**. *Optional* and *Not applicable* information is displayed in normal type. Specific instructions applicable to a particular provider type are included. The table describes each form locator by referring to the number found in the left corner of each box on the CMS-1500 claim form. These boxes contain the data elements.

> *Note: These instructions apply to the IHCP guidelines only and are not intended to replace instructions issued by the NUCC. The NUCC instruction manual can be found at http://www.nucc.org.*

An example of the new claim form is included in this bulletin.

All form locator fields with a change are noted with an asterisk (*) in Table 2.

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
1	**INSURANCE CARRIER SELECTION** – Enter **X** for Traditional Medicaid. **Required**.
1a	**INSURED'S I.D. NUMBER** (FOR PROGRAM IN ITEM 1) – Enter the member IHCP identification (RID) number. Must be 12 numeric 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 automated voice-response (AVR) system, electronic claim submission (ECS), Omni, or Web interChange verification. **Required**.
3	PATIENT'S BIRTH DATE – Enter the member's birth date in MMDDYY format. Optional. SEX – Enter an **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	PATIENT STATUS – Enter **X** the appropriate box. Optional.
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	OTHER INSURED'S DATE OF BIRTH – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, enter the requested policyholder birth date in MMDDYY format. Optional. SEX – Enter **X** in the appropriate box. Optional.
9c	**EMPLOYER'S NAME OR SCHOOL NAME** – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, enter the requested policyholder information. **Required, if applicable**.

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
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 information. **Required, if applicable.**
10	**IS PATIENT'S CONDITION RELATED TO** – Enter **X** in the appropriate box in each of the three categories. This information is needed for follow-up third party recovery actions. **Required, if applicable**.
10a	**EMPLOYMENT?** (CURRENT OR PREVIOUS) – Enter **X** in the appropriate box. **Required, if applicable**.
10b	**AUTO ACCIDENT?** – Enter **X** in the appropriate box. **Required, if applicable**. **PLACE (State)** – Enter the two-character state code. **Required, if applicable**.
10c	**OTHER ACCIDENT?** – Enter **X** in the appropriate box. **Required, if applicable**.
10d	RESERVED FOR LOCAL USE – Not applicable.
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**.
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**.
11c	**INSURANCE PLAN NAME OR PROGRAM NAME** – Enter the member's insurance plan name or program name. **Required, if applicable.**
11b	**EMPLOYER'S NAME OR SCHOOL NAME** – Enter the re quested member information. **Required, if applicable.**
11d	**IS THERE ANOTHER HEALTH BENEFIT PLAN?** Enter **X** in the appropriate box. If the response is *Yes*, complete Fields 9a–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** (First symptom date) **OR INJURY** (Accident date) **OR PREGNANCY** (**LMP date**) – Enter the date of the last menstrual period (LMP) for pregnancy-related services in MMDDYY format. **Required for payment for pregnancy-related services.**
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE – Enter date in MMDDYY format. Optional.
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION –** 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. **Required, if applicable.** For waiver related services, enter the provider name of the case manager. **Required for Medicaid *Select* PMP**. *Note: The term* referring provider *includes those physicians primarily responsible for the authorization of treatment for lock-in or restricted card members.*

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
17a*	**ID NUMBER OF REFERRING PROVIDER, ORDERING PROVIDER OR OTHER SOURCE** The qualifier indicating what the number represents is reported in the first box of 17a. The ID number (IHCP provider number or taxonomy) is reported following the qualifier in the second box of 17a. **Required for Medicaid Select PMP.** **Qualifiers/ID Number to report to IHCP:** **1D** is the qualifier that applies to the IHCP provider number also called the LPI. The LPI includes nine numeric characters and one alpha character for the service location. Atypical providers are not required to report the NPI and will report their LPI. For example, certain transportation and waiver service providers. **ZZ** is the qualifier that applies to the provider taxonomy code. The taxonomy code includes 10 alpha-numeric characters. The taxonomy code is required when reporting an NPI.
17b*	**NPI** – Enter the 10-digit numeric NPI of the referring provider, ordering provider, or other source. **Required for all healthcare providers, except atypical providers as of May 23, 2007.**
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES –** Enter the requested FROM and TO dates in MMDDYY format. **Required, if applicable.**
19	**RESERVED FOR LOCAL USE –** Enter the *Medicaid Select* primary medical provider (PMP) two-digit alphanumeric certification code. **Required for *Medicaid Select* members when the physician rendering care is not the PMP or a physician in the PMP's group or a clinic.** *Report the PMP qualifier and ID number in 17a.*
20*	OUTSIDE LAB? – Not applicable. CHARGES – Not applicable.
21.1 to 21.4.	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY –** Complete Fields 21.1., 21.2., 21.3., and/or 21.4 to field 24E by detail line. Enter the ICD-9-CM diagnosis codes in priority order. A total of four codes can be entered. At least one diagnosis code is required for all claims except those for waiver, transportation, and medical equipment and supply services. **Required**.
22	MEDICAID RESUBMISSION CODE, ORIGINAL REF. NO. – Applicable for Medicare Part B crossover claims only. For crossover claims the combined total of the Medicare coinsurance, deductible, and psych reduction must be reported on the left side of field 22 under the heading *Code*. The Medicare paid amount (actual dollars received from Medicare) must be submitted in field 22 on the right side under the heading *Original Ref No*. **Required, if applicable.**
23	PRIOR AUTHORIZATION NUMBER – The prior authorization (PA) number is not required, but entry is recommended to assist in tracking services that require PA. Optional.
Date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. *For services requiring authorization, the FROM date of service cannot be prior to the date the service was authorized. The TO date of service cannot exceed the date the specific service was terminated.*	

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
24A to 24I* Top Half – Shaded Area	**NATIONAL DRUG CODE INFORMATION –** The shaded portion of fields 24A to 24I will be used to report NDC information. **Required as of July 1, 2007.** To report this information, begin at field 24A as follows: 1. Enter the NDC qualifier of N4 2. Enter the NDC 11-digit numeric code 3. Enter the drug description 4. Enter the NDC Unit qualifier • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Unit 5. Enter the NDC Administered Amount in the format 9999.99
24A Bottom Half	**DATE OF SERVICE** – Provide the FROM and TO dates in MMDDYY format. Up to six FROM and TO dates are allowed per form. **Required**.
24B	**PLACE OF SERVICE** – Use the POS code for the facility where services were rendered**. Required.** For a complete listing of POS codes, go to http://cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of Serice.pdf.
24C*	**EMG** – Emergency indicator. This field indicates services were for emergency care for service lines with a CPT® or HCPCS code in field 24D. Enter **Y** or **N**. **Required, if applicable.**
24D	**PROCEDURES, SERVICES, OR SUPPLIES** **CPT/HCPCS** – Use the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line. **Required**. **MODIFIER** – Use the appropriate modifier, if applicable. Up to four modifiers are allowed for each procedure code. **Required, if applicable**.
24E	**DIAGNOSIS CODE –** Enter number 1–4 corresponding to the applicable diagnosis codes in field 21. A minimum of one and a maximum of four diagnosis code references can be entered on each line. **Required**.
24F	**$ 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 of other lines. This is a ten digit numeric field. **Required.**
24G	**DAYS OR UNITS** – Provide the number of units being claimed for the procedure code. Six digits are allowed, and 9999.99 units is the maximum that can be submitted. The procedure code may be submitted in partial units, if applicable. **Required.**
24H	**EPSDT Family Plan** – If the patient is pregnant, indicate with a **P** in this field on each applicable line. **Required, if applicable**.

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
24I* Top Half - Shaded Area	**RENDERING ID QUALIFIER –** Enter the *Qualifier* indicating what the number reported in the shaded area of 24J represents. Either 1D for IHCP rendering provider number or ZZ for rendering provider taxonomy code **Required**. **Qualifiers or ID number to report to IHCP:** **1D** is the qualifier that applies to the IHCP provider number (LPI). The LPI includes nine numeric characters and one alpha character for the service location. Atypical providers are not required to report the NPI and will report their LPI. For example, certain transportation and waiver service providers. **ZZ** is the qualifier that applies to the provider taxonomy code. The taxonomy code includes 10 alpha-numeric characters. The taxonomy code is required when reporting an NPI.
24J* Top Half – Shaded Area	**RENDERING PROVIDER ID** – Enter either the LPI if entering the 1D qualifier in 24I or the taxonomy if entering the ZZ qualifier in 24I for the Rendering Provider ID. **Required, if applicable.** **LPI** – The entire nine-digit LPI must be used. If billing for case management, the case manager's number must be entered here. If billing for mid-level practitioners, the supervising physician's rendering provider number must be entered here. **Taxonomy** – Enter the taxonomy code of the rendering provider if you are entering the NPI in the bottom half of 24J.
24 J* Bottom Half	**RENDERING PROVIDER NPI –** Enter the NPI of the rendering provider. **Required if applicable.**
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 service line charges in column 24F. This is a 10-digit field, such as 99999999.99. **Required.**
29	**AMOUNT PAID** – Enter the payment received from any other source, excluding the 8A deductible and the Medicare paid amount. All applicable items are combined and the total entered in this field. This is a 10-digit field. **Required, if applicable.** Other insurance – Enter the amount paid by the other insurer. If the other insurer was billed but paid zero, enter **0** in this field. Attach denials to the claim form when submitting the claim for adjudication.
30	**BALANCE DUE –** TOTAL CHARGE (Field 28) – AMOUNT PAID (Field 29) = BALANCE DUE (Field 30). This is a 10-digit field, such as 99999999.99. **Required.**
31	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS** – An authorized person, someone designated by the agency or organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not. Providers who have signed the *Signature on File* certification form will have their claims processed when a signature is omitted from this field. The form is available on the IHCP Web site, *Provider Services* page at http://www.indianamedicaid.com/ihcp/ProviderServices/provider_enroll.asp. **Required if applicable.** **DATE** – Enter the date the claim was filed. **Required.**
32*	SERVICE FACILITY LOCATION INFORMATION – Enter the provider's name and address where the services were rendered, if other than home or office. This field is optional, but it helps EDS contact the provider, if necessary. Optional.
32a*	SERVICE FACILITY LOCATION NPI – Not applicable.

Table 2 – CMS-1500 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
32b*	SERVICE FACILITY LOCATION QUALIFIER AND ID NUMBER – Not applicable.
33*	**BILLING PROVIDER INFO & PH #** – Enter the billing provider service location name, address, and the expanded ZIP Code + 4 format. **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.*
33a*	**BILLING PROVIDER NPI** – Enter the billing provider NPI. **Required, if applicable.**
33b*	**BILLING PROVIDER QUALIFIER AND ID NUMBER –** Enter a billing provider qualifier of ZZ and taxonomy code for a NPI. If the billing provider is an atypical provider, enter the qualifier 1D and the LPI. **Required**. *During the transition period, billing provider may report the qualifier 1D and the LPI.* *Note: Qualifiers are ZZ = Taxonomy and 1D = IHCP provider number (LPI)*

CMS-1500, Effective April 1, 2007