Mental Health Guidelines and Billing Practices

HP Provider Relations
July 2011
Agenda

– Session Objectives
– Outpatient Mental Health
– Medicaid Rehabilitation Option (MRO)
– Risk-Based Managed Care (RBMC)
– Eligibility Inquiry
– Web interChange and CMS-1500 Billing Guidelines
– Helpful Tools
– Questions
Objectives

At the end of this presentation, providers will understand the following:

– Outpatient coverage requirements
– MRO services
– Meaning of rolling 12-month period
– Role of the health service provider in psychology (HSPP)
– Managed care carve-in
– How to verify member eligibility
– How to submit claims via the Web interChange and the CMS-1500 claim form
Understand
Outpatient Mental Health
Mental Health

– The Indiana Health Coverage Programs (IHCP) under the direction of the Indiana Administrative Code (IAC) 405 IAC 5-20-8 reimburses for outpatient mental health services when provided by:
  • Licensed physicians
  • Psychiatric hospitals
  • Psychiatric wings of acute care hospitals
  • Outpatient mental health facilities
  • Licensed psychologists with the HSPP designation
Mental Health

– The IHCP also reimburses under 405 IAC 5-20-8 for psychiatrist or HSPP-directed outpatient mental health services when provided by mid-level practitioners:
  • Licensed clinical social worker (LCSW)
  • A person holding a masters degree in social work (MSW), marital and family therapy or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed
  • Licensed psychologist
  • Licensed independent practice school psychologist
  • Licensed marriage and family therapist (LMFT)
  • Licensed mental health counselor (LMHC)
  • An Advanced practice nurse who is a licensed, registered nurse with a master’s degree in nursing with a major in psychiatric and mental health nursing from an accredited school of nursing

– Mid-level practitioners are not enrolled by the IHCP
Mental Health
Psychiatrist or HSPP responsibilities

– Must certify the diagnosis and supervise the plan of treatment as stated in 405 IAC 5-20-8 (3) (a)-(b)

– Must see the patient or review information obtained by a mid-level practitioner within seven days of intake

– Must see the patient or review documentation to certify treatment plan and specific modalities at intervals not to exceed 90 days

– Must document and personally sign all reviews
  • No cosignatures on documentation

– Must be available for emergencies
  • An emergency is a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in (1) danger to the individual, (2) danger to others, or (3) death of the individual
Mental Health

PA requirements

– Prior authorization (PA) is required for units in excess of 20 per member, per rendering provider, per rolling 12-month period:
  • Codes below in combination are subject to 20 units per member, per provider, per rolling 12-month period:
    – 90804 through 90815
    – 90845 through 90857
    – 96151 through 96153

– Requests for PA should include a current plan of treatment and progress notes to support the effectiveness of therapy

– Reference the IHCP Provider Manual Chapter 6 for prior authorization guidelines and instructions
  • Managed care entities (MCEs) may have different PA requirements; providers are encouraged to contact each MCE for PA processes
Mental Health
What is a rolling 12-month period?

– A rolling 12-month period is:
  • Based on the first date that services are rendered by a particular provider
  • Renewable one unit at a time beginning 365 days after the date that services are rendered by a particular provider

– It is not:
  • Based on a 12-month calendar year
  • Based on a fiscal year
  • Renewable on January 1 of each year
Mental Health

Psychiatric diagnostic interview (90801)

– One unit of psychiatric diagnostic interview (90801) is allowed per member, per provider, per rolling 12-month period per IAC 405 IAC 5-20-8 (14)

– Additional units require PA

– Exception: Two units are allowed without PA if separate evaluations are performed by a psychiatrist or HSPP and a mid-level practitioner
Mental Health Prior Authorization

– Mail or Fax PA requests to:

   ADVANTAGE Health Solutions-FFS
   P.O. Box 40789
   Indianapolis, IN 46240

   Fax number: 1-800-689-2759

– For questions or inquiries, call 1-800-269-5720

– For Rick based managed care (RBMC) members, contact the appropriate Managed Care Entity (MCE)
Care Select Organizations – Prior Authorization

– ADVANTAGE Health Solutions
  • advantageplan.com
    P.O. Box 80068
    Indianapolis, IN 46280
    Phone: 1-800-784-3981
    Fax request: 1-800-689-2759

– MDwise
  • mdwise.org
    P.O. Box 44214
    Indianapolis, IN 46244-0214
    Phone: 1-866-440-2449
    Fax request: 1-877-822-7186
Physician, HSPP Covered Services

- Medical services provided by mid-level practitioners, such as clinical social workers, clinical psychologists, or any mid-level practitioners (excluding nurse practitioners and clinical nurse specialists) are not reimbursable for the following codes:
  - 90805
  - 90807
  - 90809
  - 90811
  - 90813
  - 90815
  - 90862
Physician, HSPP Covered Services

- PA is always required for neuropsychological and psychological testing
  - 96101 – Psychological Testing
  - 96110 – Developmental Testing
  - 96111 – Developmental Testing Extended
  - 96118 – Neuropsychological Testing Battery
    - According to 405 IAC 5-2-8(7), a physician or HSPP must provide these services
Mental Health
Noncovered services

– Biofeedback
– Broken or missed appointments
– Day care
– Hypnosis
Mental Health

Billing overview

- Services are billed on the 837P or the CMS-1500 paper claim form
- Services are billed using the National Provider Identifier (NPI) of the facility or clinic, and the rendering NPI of the supervising psychiatrist or HSPP
- Medical records must document the services and the length of time of each therapy session
- Psychiatrists and HSPPs are reimbursed at 100 percent of the allowed amount
- Mid-level practitioners are reimbursed at 75 percent of the allowed amount
  - Services rendered by mid-level practitioners are billed using the rendering NPI of the overseeing provider
Mental Health
Billing overview

– Appropriate modifiers must be used for mid-level practitioners
  • AH – Clinical psychologist
  • AJ – Clinical social worker
  • HE and SA – Nurse practitioner or nurse specialist
  • HE – Any other mid-level practitioner as addressed in the 405 IAC 5-20-8
  • HO – Master’s degree level
  • SA – Nurse practitioner or clinical nursing specialist (CNS) in a nonmental health arena
Mental Health

Billing overview

– Mental health providers that submit claims with procedure codes and append modifier HE or HO when the member is dually eligible for Medicare and Medicaid may now utilize claim notes for billing to indicate that the provider has performed a service that is not approved to bill to Medicare

  • Claims submitted using claim notes must indicate in the claim notes on the 837P 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
Learn
MRO Services
MRO (Medicaid Rehabilitation Option)

- The Office of Medicaid Policy and Planning (OMPP), in conjunction with the Division of Mental Health and Addiction (DMHA), developed a benefit plan structure for Medicaid members receiving MRO services.
- While members can continue to access MRO providers based on a self-referral, members who have a qualifying MRO diagnosis will be assigned a service package based on their individual level of need (LON).
Importance of Verifying Eligibility

– It is important that providers verify member eligibility on the date of service

– Viewing a Hoosier Health card alone does not ensure member eligibility

– If a provider fails to verify eligibility on the date of service, the provider risks claim denial

– Claim denial could result if the member was not eligible on the date of service

– If the member is not eligible for Medicaid on the date of service, the member can be billed
  • If retroactive eligibility is later established, the provider must bill the IHCP and refund any payment made to the provider by the member
Service Package Process

An MRO-approved provider completes a Child and Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA)

The level of need (LON) and diagnosis are submitted into the Data Assessment Registry Mental Health and Addiction (DARMHA) system by the provider

The information is sent to HP Enterprise Services to systematically load the MRO service package
When to Submit a Prior Authorization

– If a member requires additional medically necessary services, a PA request is required

– Please note that submitting a PA request for a full service package is not permitted

– Under the following four scenarios, an MRO service provider is required to submit a PA request to the PA vendor:

  • **Scenario 1:** A member depletes units within his or her MRO service package and requires additional units of a medically necessary MRO service.
  
  • **Scenario 2:** A member requires a medically necessary MRO service not authorized in his or her MRO service package.
  
  • **Scenario 3:** A member does not have one or more qualifying MRO diagnoses and/or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
  
  • **Scenario 4:** A member is newly eligible to the Medicaid program or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive PA request is appropriate for MRO services provided during the retroactive period.
Prior Authorization
Prior authorization by telephone, fax, or mail

– ADVANTAGE Health Solutions
  Prior Authorization Department
  P.O. Box 40789
  Indianapolis, IN 46240

– Phone: 1-800-269-5720
  Fax: 1-800-689-2759
Medicaid Rehabilitation Option

– Medicaid Rehabilitation Option (MRO) services remain carved out of the risk-based managed care (RBMC) delivery system

– MRO services remain reimbursable only to providers enrolled as type 11 (mental health) with a specialty of 111 (community mental health center)

– Clinical mental health services are provided for individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness

– Services must be reported with an HW modifier
MRO Covered Services

– The following services are covered:
  • Behavioral Health Counseling and Therapy (Individual and Group setting)
  • Behavioral Health Level of Need Redetermination
  • Case Management
  • Psychiatric Assessment and Intervention
  • Adult Intensive Rehabilitative Services (AIRS)
  • Child and Adolescent Intensive Resiliency Service (CAIRS)
  • Intensive Outpatient Treatment (IOT)
  • Addiction Counseling (Individual and Group setting)
  • Peer Recovery Services
  • Skills Training and Development (Individual and Group setting)
  • Medication Training and Support (Individual and Group setting)
  • Crisis Intervention

– Reminder: Do not use mid-level modifiers when billing for MRO services
MRO Provider Qualifications

– Three categories of provider types can render MRO services:
  • Licensed Professional
  • Qualified Behavioral Health Professional (QBHP)
  • Other Behavioral Health Professional (OBHP)

– For a detailed list of qualified providers, please see the following resources:
  • MRO Provider Manual located on the indianamedicaid.com Web site under Manuals
  • The Family Social Services Administration (FSSA) public Web site at https://myshare.in.gov/FSSA/ompp/MRO/default.aspx
Define
Risk-Based Managed Care (RBMC)
Risk-Based Managed Care

- Services that are the responsibility of the MCEs:
  
  • Office visits with a mental health diagnosis
  
  • Services ordered by a provider enrolled in a mental health specialty, but provided by a nonmental health specialty, such as a laboratory and radiology
  
  • Mental health services provided in an acute care hospital
  
  • Inpatient stays in an acute care hospital or freestanding psychiatric facility for treatment of substance abuse or chemical dependency
Risk-Based Managed Care

- Services provided to RBMC members by the following specialty types are the responsibility of the MCEs:
  - Freestanding Psychiatric Hospital (011)
  - Outpatient Mental Health Clinic (110)
  - Community Mental Health Center (111)
  - Psychologist (112)
  - Certified Psychologist (113)
  - HSPP (114)
  - Certified Clinical Social Worker (115)
  - Certified Social Worker (116)
  - Psychiatric Nurse (117)
  - Psychiatrist (339)
Risk-Based Managed Care

– MCEs
  • Anthem anthem.com
  • Managed Health Services (MHS) managedhealthservices.com
  • MDwise mdwise.org

– Behavioral Health Organizations (BHO)
  • Anthem anthem.com
  • Cenpatico (MHS) cenpatico.com
  • MDwise mdwise.org
Understand
Eligibility Verification System
Importance of Verifying Eligibility

- It is important that providers verify member eligibility on the date of service
- Viewing a Hoosier Health card alone does not ensure member eligibility
- If a provider fails to verify eligibility on the date of service, the provider risks claim denial
- Claim denial could result if the member was not eligible on the date of service
- If the member is not eligible on the date of service, the member can be billed for services
  • However, it is important to remember that if retroactive eligibility is later established, the provider must bill the IHCP and refund any payment made to the provider by the member
Methods to Verify Eligibility

- Providers can verify eligibility by using one of the following eligibility verification methods:
  - Web interChange
    - [https://interchange.indianamedicaid.com](https://interchange.indianamedicaid.com)
  - Omni swipe card device
    - Requires upgrade for benefit limit information (refer to IHCP Provider Bulletin BT200711)
    - Omni instructions are in Chapter 3 of the *IHCP Provider Manual*
  - Automated Voice Response (AVR)
    - Contact AVR at (317) 692-0819 in the Indianapolis local area or 1-800-738-6770
    - AVR instructions are in Chapter 3 of the *IHCP Provider Manual*

Providers using any of these systems may verify member eligibility seven days a week, 24 hours a day
Welcome to Web interChange

This secure website allows you to inquire upon your Indiana Health Coverage Programs claim information quickly and easily.

Logon to Web interChange

Already have a User ID and password?

If you already have a User ID and password, enter that information in the following spaces.

User ID
Password

Log On

Forget your password?

Reset it yourself! The Reset Password function allows the user to reset their own password. For more information regarding the Reset Password functionality, visit the Automated Password Reset Help page.

OR

Go to your group administrator to have your password reset, or, if you don’t yet have an administrator, call the Electronic Solutions Helpdesk @ (317) 488-5160. To find an administrator for your organization, please use the Administrator Listing function.

First time here?
Administrator Request Form

– Complete and mail the Administrator Request Form and owner letter to:

  • Electronic Solutions Help Desk
    950 N. Meridian Street
    Suite 1150
    Indianapolis, IN 46204-4288

– Request form and owner letter may be faxed to (317) 488-5185

– The owner letter indicates you are approved as a Web interChange administrator for your organization

– Each provider should assign a Web interChange administrator to oversee the daily functions of the individual practice or group
Welcome to Web interChange - a secure website that allows you to inquire upon your Indiana Health Coverage Programs claim information quickly and easily.

**Claim Inquiry** allows you to inquire on your previously submitted claims - even before they make it to the RA. You can find your claim by searching within a date range, by claim type, member ID or by ICN. Once the basic claim information is displayed, simply click on that line to get the detailed information on that claim. In keeping with CMS privacy requirements, built-in security features allow only the billing provider to view the claims they submit.

**Claim Submission** allows you to electronically submit claims to the Indiana Health Coverage Programs via the Internet. All institutional, professional, and Dental claims can be entered on this site. This includes Inpatient, Outpatient, Home Health, Long Term Care, Medical, as well as Indicare Crossover claims.

**Eligibility Inquiry** allows you to inquire on the eligibility of an Indiana Health Coverage Programs Member utilizing a number of search criteria. The response will include eligibility information as well as other helpful fields such as Managed Care and TPL information.

**User Lists** allow you to build custom data lists to be used when electronically submitting claims to the Indiana Health Care Program via the Internet.

**Check RA Inquiry** allows you to inquire on your previously received payments. You can find your check or Electronic Funds Transfer, as well as any Remittance Advice (RA), by searching within a date range or by searching for a specific check number. Once the basic check information is displayed, simply click on that line to get a list of all the claims that are associated with that check. If a RA is available for a specific date, you can click on the icon to view and/or save a copy of the RA. RAs are available online for a limited number of weeks. In keeping with CMS privacy requirements, built-in security features allow only the billing provider to view the checks that they have received.

**Prior Authorization Inquiry** allows you to inquire on previously submitted requests for Prior Authorization.

**Prior Authorization Submission** allows you to electronically submit requests for Prior Authorization to the Indiana Health Coverage Programs via the Internet.

**Provider Profile** allows you to view profile information as an Indiana Health Coverage Provider.

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**What's New**

- **Third Quarter 2009 Workshops Are Here!**
  - The IHP is offering current provider workshops free of charge. Topics include HIPAA, HealthView Open Enrollment, EPSDT, Blood Lead Testing and more. Please click here to view the workshop in your area and sign up today! You may also contact the workshop line at 317-405-5072 for additional information.

- **Coming Soon**
  - Action Required to Access Remittance Advises after September 1, 2009.
  - Provider Communications Going Green!

  Effective September 1, 2009, Banner Payers, Newsletters (including Drug Utilization Review Board newsletters), Bulletins, and Remittance Advises will no longer be printed and mailed but will be available online only. Claim Correction Forms (CCFs) will no longer be mailed. For more information, please see Action Required to Access Remittance Advises after September 1, 2009 in newsletter N-2009-3.

  Note: The last paper RA financial cycle is August 2009, and will be mailed September 1. The next RA financial cycle (September) is on September 4-5 and will be posted on Web interChange September 7.
Verifying Member Eligibility

Eligibility Inquiry window

Eligibility Inquiry

Query Information:
- Search For: NPI, Legacy Provider ID
- NPI: 
- Taxonomy Code: 
- Postal Code: 
- Search Criteria: By Member ID
- Member ID: 
- From Date: 05/08/2010
- To Date: 05/08/2010

Eligibility Information: None

Spend-Down: None

Managed Care Information: None

Third Party Carrier Information: None

County Information: None

Benefit Limits Reached For Inquiring Provider Type: 

Search Reset
Eligibility Inquiry Window
Learn
Web interChange and CMS-1500 Billing Guidelines
## Claims Processing Menu

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### Institutional Claims
- Inpatient
- Outpatient
- Home Health
- Long Term Care
- Institutional Crossover
- Outpatient Crossover

### Professional Claims
- Medical (includes HCBS Waiver)

### Dental Claims
- Dental

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**Helpful Hints**
- Use the [NPI Reporting Tool](#) to report your National Provider Identifier (NPI) to IHCP.
- Click on any field label to get more information about the field.
- Review the [Help Page](#) to find more information about how to use this site.
- Please direct comments, problems or suggestions concerning using this site to [Indiana Medicaid](#).
# Professional Claim

![Professional Claim Form](image)

- **Billing Information**
  - *NP*
  - *Legacy Provider Id*
  - *Member ID*
  - *Last Name*
  - *First Name*
  - *Patient Account #*
  - *Rendering NPI*
  - *Rendering Taxonomy*
  - *Referring NPI*
  - *Referring Taxonomy*
  - *Certification Code*
  - *Signature Indicator*
  - *Medical Record #*

- **Service Information**
  - **Claim Type**
  - **Medical Crossover**
  - *Place of Service*
  - *Hospital From Date*
  - *Hospital To Date*
  - *Pregnancy?*
  - *Related to Accident?*
  - *Last Menstrual Period*
  - *Special Program*

- **Coordination of Benefits**
  - **Total TR**
  - **Total Medicare Paid**

- **Benefit Information**

- **Diagnosis Code**
  - Primary Diagnosis
  - Diagnosis 2
  - Diagnosis 3
  - Diagnosis 4

- **Charges**
  - Total Charges
Web interChange Claim Submission

- Under the Professional heading, click the Medical link
- Your Billing National Provider Identifier (NPI) will automatically populate in the NPI field
- Complete the fields:
  - Member’s ID
  - Last Name, First Name
  - Patient Acct #, Rendering NPI
  - Place of Service
  - Diagnosis Code(s)
Professional Claim

![Image of a professional claim form]

Mental Health Guidelines and Billing Practices

July 2011
Web interChange Claim Submission

Detail Information
- From DOS, To DOS
- Procedure Code, Modifiers
- Related Diagnosis (if needed)
- Units
- Charges
- Click Save Detail and a summary of the detail information displays in the box at the bottom of the screen to confirm that the information saved
- Click Submit Claim on the bottom of the screen
- When the confirmation pop-up window appears with the claim’s internal control number (ICN), confirm the information, and click OK to complete the process and send the claim to HP

*Note: Users who are running pop-up blockers will not see the confirmation window.
Please disable all pop-up blockers when using Web interChange.*
CMS-1500 Claim Form

**HEALTH INSURANCE CLAIM FORM**

**MEDICARE MEDICAID TRICARE**

1. **INSURANCE**
   - Medicare
   - Medicaid
   - CHAMPVA
   - TRICARE
   - Other

2. **PATIENT'S NAME** (Last Name, First Name, Middle Initial)
   - ( )

3. **PATIENT'S DATE OF BIRTH**
   - DD: MM: YY
   - SEX

4. **INSURED'S NAME** (Last Name, First Name, Middle Initial)

5. **PATIENT'S RELATIONSHIP TO INSURED**
   - Self
   - Spouse
   - Child
   - Other

6. **INSURED'S ADDRESS** (No., Street)
   - City
   - State
   - ZIP Code

7. **PATIENT'S STATE**
   - Single
   - Married
   - Other

8. **ZIP CODE**
   - TELEPHONE (Include Area Code)

9. **EMPLOYER'S NAME**
   - EMPLOYER'S SOCIAL SECURITY NUMBER

10. **EMPLOYER INFORMATION**
    - EMPLOYER'S NAME OR SCHOOL NAME

11. **INSURED'S POOR AREA GROUP OR FECA NUMBER**
    - POOR AREA GROUP OR FECA NUMBER

12. **INSURED'S PLAN NAME OR PROGRAM NAME**
    - DATE

13. **READ EACH OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

14. **DATE OF CURRENT OCCURRENCE**
    - DD: MM: YY

15. **PATIENT IS DECEASED OR SIMILAR ILLNESS**
    - GIVE FIRST DATE
    - DD: MM: YY

16. **DATE PATIENT WAS UNABLE TO WORK OR INJURY**
    - DD: MM: YY

17. **NAME OF REFERENCING PROVIDER OR OTHER SOURCE**
    - NPI

18. **RESERVED FOR LOCAL USE**
    - YES

19. **DIAGNOSIS**
    - DIAGNOSIS NO.

20. **FEDERAL TAX ID NUMBER**
    - SSN

21. **PATIENT'S ACCOUNT NO.**
    - 27. **ACCORD ASSIGNMENT**
      - YES

22. **TAXABLE AMOUNT**
    - 30. **BALANCE DUE**
      - S

23. **SIGNATURE OF PHYSICIAN OR PROVIDER**
    - (Include Degrees or Credentials)

**NUCC Instruction Manual available at: www.nucc.org**

**APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)**

**MENTAL HEALTH GUIDELINES AND BILLING PRACTICES**

**July 2011**

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**CMS-1500 Claim Form**

- **Insurance Type:** Medicare, Medicaid, CHAMPVA, TRICARE, Other
- **Patient's Name:** (Last Name, First Name, Middle Initial)
- **Patient's Date of Birth:** DD: MM: YY
- **Insured's Name:** (Last Name, First Name, Middle Initial)
- **Patient's Relationship to Insured:** Self, Spouse, Child, Other
- **Insured's Address:** No., Street, City, State, ZIP Code
- **Patient's State:** Single, Married, Other
- **ZIP Code:** Telephone (Include Area Code)
- **Employer's Name:** Employer's Social Security Number
- **Insured's Plan Name or Program Name:**
- **Date of Current Occurrence:** DD: MM: YY
- **Patient is Deceased or Similar Illness:** Give First Date DD: MM: YY
- **Date Patient Was Unable to Work or Injury:** DD: MM: YY
- **Name of Referring Provider or Other Source:** NPI
- **Reserved for Local Use:** YES
- **Diagnosis:** Diagnosis No.
- **Federal Tax ID Number:** SSN
- **Patient's Account No.:**
- **Accord Assignment:** YES
- **Taxable Amount:** S
- **Balance Due:** S
- **Signature of Physician or Provider:** (Include Degrees or Credentials)

**Mental Health Guidelines and Billing Practices**

**July 2011**

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**Mental Health Guidelines and Billing Practices**

- **July 2011**
CMS-1500 Billing Guidelines

- 1a INSURED’S I.D. NUMBER
- 2 PATIENT’S NAME
- 21.1 to 21.4. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
- 23 PRIOR AUTHORIZATION NUMBER – The prior authorization (PA) number is not required, but entry is recommended to assist in tracking services that require PA
- 24A DATE OF SERVICE
- 24B PLACE OF SERVICE – Use the POS code for the facility where services were rendered
- 24D HCPCS and MODIFIER – Use the appropriate procedure code for the service rendered
- 24E DIAGNOSIS POINTER
- 24F CHARGES
- 24G DAYS OR UNITS
CMS-1500 Billing Guidelines

- 24 J Bottom Half RENDERING PROVIDER ID# NPI – Enter the NPI of the rendering provider.
- 28 TOTAL CHARGE
- 30 BALANCE DUE
- 31 SIGNATURE OF PHYSICIAN – 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 Provider Services page on indianamedicaid.com
- 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 HP contact the provider, if necessary.
- 33 BILLING PROVIDER INFO – Enter the billing provider service location name, address, and the expanded ZIP Code + 4 format. Required.
Additional Billing Resources

- Paper billing resources
  - *IHCP Provider Manual* on the [indianamedicaid.com Manuals](http://www.indianamedicaid.com) Page – Chapter 8, Section 4

- Web interChange resources
  - Quick Reference for billing medical claims
Claim Inquiry

To view claim status on submitted claims
Find Help

Resources Available
Helpful Tools

– IHCP Web site at [indianamedicaid.com](http://indianamedicaid.com)
– IHCP Provider Manual
– MRO Provider Manual
  • 405 IAC 5-20 (Mental Health Services)
  • 405 IAC 5-21 (Community Mental Health Rehabilitation Services)
  • 405 IAC 5-21.5 (Medicaid Rehabilitation Option Services)
– Customer Assistance
  • 1-800-577-1278 toll-free
  • (317) 655-3240 in the Indianapolis local area
– HP Written Correspondence at the following address:
  HP Written Correspondence
  P.O. Box 7263
  Indianapolis, IN 46207-7263
– Provider Relations field consultants
Q&A