

Fee-for-Service Vision

Indiana Health Coverage Programs
DXC Technology
Annual Seminar – October 2019



Agenda



- Provider References
- IHCP Provider Healthcare Portal
- Coverage
- Secondary Claims on the IHCP Provider Healthcare Portal
- Helpful Tools
- Questions



Provider References



Provider References

Stay informed at
in.gov/medicaid/providers:

- *News, Bulletins, and Banner Pages*
- Email notifications
- Code sets
- Professional Fee Schedule
- *Vision Services* provider reference module

 INDIANA MEDICAID <i>for Providers</i>	 Provider Enrollment	 Provider References
News, Bulletins, and Banner Pages		
IHCP Email Notifications		
Provider Reference Materials		
Forms		
IHCP Provider Locator		
OPR Provider Verification		
FAQs - Top 10 Questions		



Provider References

INDIANA MEDICAID <i>for Providers</i>	Provider Enrollment	Provider References	Provider Education	Business Transactions	Clinical Services	About IHCP Programs	Contact Information
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IHCP Provider Reference Modules

For information about IHCP policies and procedures, including billing guidance, refer to the **IHCP Provider Reference Module** appropriate to the topic of interest.

Provider References

Vision Services Module

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Any published IHCP Bulletin or Banner Page past the module's policies and procedures effective date supersedes the module

Provider References Vision Code Sets



MENU

IN.gov



Business
Transactions



IHCP Provider Healthcare Portal

Eligibility Verification

Qualified Provider Presumptive Eligibility (PE)

Electronic Visit Verification

Electronic Data Interchange (EDI) Solutions

Billing and Remittance

Program Integrity

Health Insurance Portability and Accountability Act (HIPA

Indiana Medicaid Promoting Interoperability Program

Billing and Remittance

Whether you're new to Medicaid or have been a provider for years, this section is designed to help answer your billing questions. Find links to provider code sets, fee schedules, and more.



Provider References

Vision Code Sets

[INDIANA MEDICAID](#) / [IHCP PROVIDERS](#) / [BUSINESS TRANSACTIONS](#) / BILLING AND REMITTANCE

As a Medicaid provider, what's the best way for you to submit claims to the Indiana Health Coverage Programs (IHCP)? It's a big topic, and an important one. Whether you're new to Medicaid or have been a provider for years, the following pages are designed to help answer your billing and remittance questions:

- [Code Sets](#)
- [IHCP Fee Schedules](#)
- [Long Term Care DME Per Diem Table](#)
- [Diagnosis-Related Group Inpatient Reimbursement](#)
- [Explanation of Benefits \(EOB\)](#)
- [Best Practices for Nonpharmacy Claims](#)
- [Claim Administrative Review and Appeal](#)



Provider References

Vision Services Code Sets



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER CODE TABLES

Vision Services Codes

*Note: Due to possible changes in Indiana Health Coverage Programs (IHCP) policy or national coding updates, inclusion of a code on the code tables does not necessarily indicate **current** coverage. See [IHCP Banner Pages and Bulletins](#) and the [IHCP Fee Schedules](#) for updates to coding, coverage, and benefit information.*

For information about using these code tables, see the [Vision Services](#) provider reference module.

[Table 1 – Covered Procedure Codes for Opticians \(Specialty 190\)](#)

[Table 2 – Covered Procedure Codes for Optometrists \(Specialty 180\)](#)

[Table 3 – ICD-10 Diagnosis Codes for Optometrist Billing of Visual Evoked Potential \(VEP\) Testing](#)

[Table 4 – Procedure Codes for Billing Intraocular Stents Inserted in Conjunction with Cataract Surgery](#)



Business Transactions Professional Fee Schedule

IHCP Fee Schedules

The Professional Fee Schedule can be searched by Procedure Code, Procedure Code Range, or Procedure Code Description. If the search returns more than 100 records, you will be asked to further refine your search criteria. Wild card searches using special characters are not used and will display an error message.

Procedure Code: Enter at least three characters of the Procedure Code to filter by specific Procedure Code. This search criteria cannot be used in combination with the Procedure Code Range criteria.

Procedure Code Range: Enter a beginning and ending five-character Procedure Code to obtain all Procedure Codes within a range. This search criteria cannot be used in combination with the Procedure Code criteria.

Procedure Code Description: Enter a text string to obtain records containing the entered text in either the short or long Procedure Code Description. This search criteria can be used in combination with the Procedure Code or the Procedure Code Range criteria.

Procedure Code:

Procedure Code Range: to

Procedure Code Description:

* Code values are described on the [Fee Schedule Instructions](#) page.

1

Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Category	Service Category Desc	Rate Type	Pricing Method	Pricing Effective Date	Pricing End Date	PA Req'd	Attach Req'd
V2020					VISIO	Vision	Def	MAXFEE	10/5/1994			
Min-Max Units					Fee Schedule Amt:		\$20.00	Base Units:		0	Age Min-Max:	
Procedure Desc:		VISION SVCS FRAMES PURCHASES					CMS Add Date:		1/1/1985	CMS Term Date:		

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IHCP Provider Healthcare Portal



Provider Healthcare Portal

What you can do on the Portal:

- Submit, copy, edit and void claims
- Check status of claims
- Verify eligibility
- View and print Remittance Advices
- Request prior authorization
- Submit enrollment or revalidate as an IHCP provider
- Send a secure correspondence

Delegates must have the functions granted to them

INDIANA MEDICAID for Providers

Contact Us | FAQs | Login

Home

Home

Saturday 07/06/2019 02:21 PM

Login

*User ID

[Log In](#)

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

WHAT CAN YOU DO IN THE PROVIDER HEALTHCARE PORTAL?

Through the Indiana Health Coverage Programs (IHCP) secure and easy-to-use internet portal, healthcare providers can:

- Submit claims
- Check on the status of their claims
- Inquire on a patient's eligibility
- View their Remittance Advices
- Request prior authorization

Managed Care Entities can:

- Enroll, disenroll, and update primary medical providers
- Review their encounter claims
- Inquire on a managed care member's eligibility

In addition, the Portal provides access to a wide variety of IHCP information and resources.

Protect Your Privacy!
Always log off and close all of your browser windows

Would you like to enroll as a Provider?

[Provider Enrollment](#)

Drug Resources

[Fee-for-Service Pharmacy Resources](#)

Fee Schedule

[Search Fee Schedule](#)

[Website Requirements](#)

Provider Healthcare Portal Benefit Limits Details

- Certain benefit limits, including limits for vision services, are available through the Eligibility Verification System (EVS), which providers can access through any of the following methods:
 - Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers
 - Interactive Voice Response (IVR) system at 1-800-457-4584
 - 270/271 electronic data interchange (EDI) transaction



Benefit limit information is provided through the EVS options. Providers can request this information for fee-for-service (FFS) claims through Portal secure correspondence.

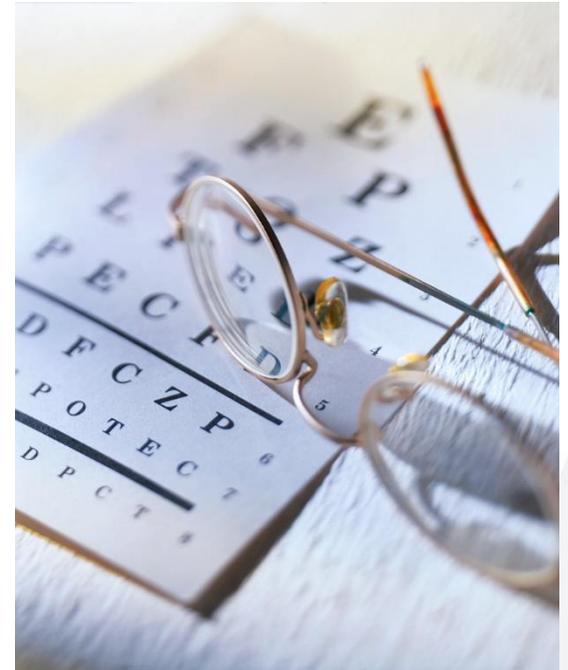
For managed care members, contact the appropriate managed care entity (MCE) for information about a member's vision service limitations.



Provider Healthcare Portal Benefit Limits Details

Vision providers may not have the most current information available about services previously rendered to a member and paid by the IHCP, such as the dates the limits were exhausted:

- This situation can result in reduced reimbursement or no reimbursement for rendered services
- Providers may submit secure correspondence through the Portal to request the date on which a particular member exceeded service limitations for fee-for-service (FFS) claims



Providers should allow up to 7-10 business days for a response.



Provider Healthcare Portal

Common Denial Benefit Limits Details

- 6195 Frames initial or repair/replacement, member over 21 years
- 6196 Frames initial or replacement, member 21 years or younger
- 6271 Lenses initial or replacement, member 21 years or younger
- 6272 Lenses initial or repair/replacement, member over 21 years
- 6297 Routine vision exam limited to 1, per 12 months, member age 0-20
- 6298 Routine vision exam limited to 1, per 24 months, member age 21-999



Coverage



Coverage Eye Exam

IHCP coverage for an initial and routine eye examination is limited to the following:

- For members under 21 years of age – One examination per 12-month period
- For members 21 years of age and older – One examination every 2 years
- When billing eye examinations, providers should use the CPT code that best describes the examination

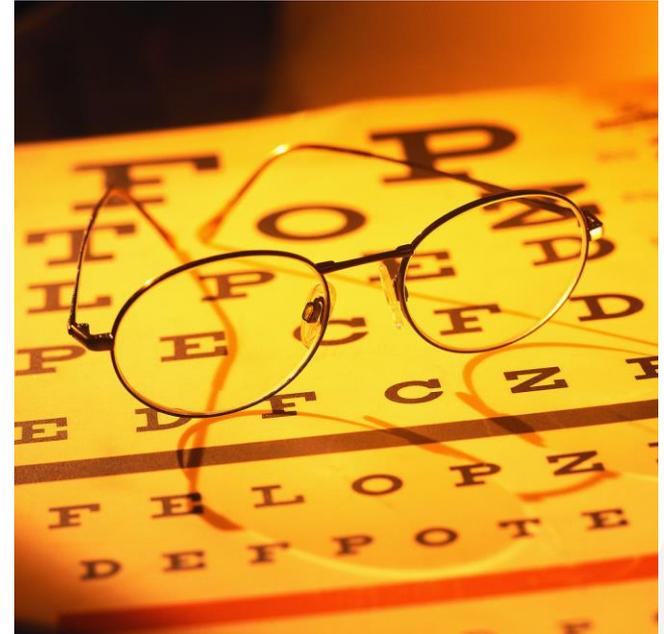


If medical necessity dictates more frequent examination or care, documentation of such medical necessity must be maintained in the provider's office and is subject to postpayment review and audit.

Coverage Eyeglasses

IHCP provides coverage for eyeglasses if minimum prescription criteria are met, with the following frequency limitations:

- Members under 21 years of age – One pair of eyeglasses per 12-month period
- Members 21 years of age or older – One pair of eyeglasses every 5 years
- Reimbursement is provided for the initial or subsequent pair of eyeglasses only when at least one of the following minimum prescription criteria is met:
 - For members 6 years of age up to age 42 – 0.75 diopters in at least one eye
 - For members 42 years of age and older – 0.50 diopters in at least one eye



Coverage Lenses

Prescription of lenses, when required, is included in CPT code 92015 – *Determination of refractive state*:

- Service includes specification of lens type:
 - Monofocal
 - Bifocal
 - Lens power, axis, and prism
 - Absorptive factor
 - Impact resistance
- IHCP does not provide coverage for all lenses. Noncovered services include:
 - Lenses with decorative designs
 - Lenses larger than size 61 millimeters, except when medical necessity is documented
 - Fashion tints, gradient tints, sunglasses, or photochromatic lenses



Coverage Lenses

If a member chooses to upgrade to progressive lenses, transitional lenses, antireflective coating or tint number other than 1 and 2, providers can bill the basic lens V code to the IHCP.



Providers can bill the upgrade portion to the member only if they gave the member appropriate advance notification of noncoverage and if a separate procedure code for the service exists.

Coverage Frames

- IHCP reimburses for frames including:
 - Plastic
 - Metal
- Providers should bill for frames using procedure code V2020
- Maximum amount reimbursed for frames is \$20.00 per pair, except when medical necessity requires a more expensive frame
- All claims for more expensive frames are billed with V2025 and must be accompanied by documentation supporting medical necessity such as:
 - Special frames to accommodate a facial deformity or anomaly
 - Frames with special modifications, such as a ptosis crutch
 - Frames for a member with an allergy to standard frame materials
 - Frames for an infant or child requiring the prescription of special-size frames
- Must submit a manufacturer's suggested retail price (MSRP) or cost invoice
 - Frames up to 75% of the MSRP or up to 120% of the cost invoice

Providers that receive payment from the IHCP for frames may not bill the member for any additional covered services above the IHCP reimbursement.



Coverage

Repair or Replacement Eyeglasses

Billing guidelines for repair or replacement eyeglasses:

- If a member needs replacement eyeglasses due to loss, theft, or damage beyond repair before the established frequency limitations, providers must use the **modifier U8** to bill for the replacement lenses or frames
- Providers must include documentation in the member's medical record to substantiate the need for replacement frames or lenses
- Must include a signed statement by the member detailing how the eyeglasses were lost, stolen, or broken
- If a member needs replacement eyeglasses due to a change in prescription before the established frequency limitations, providers must use **modifier SC** when billing replacement lenses or frames

New or replacement glasses and frames are based on medical necessity.

Secondary Claims on the IHCP Provider Healthcare Portal

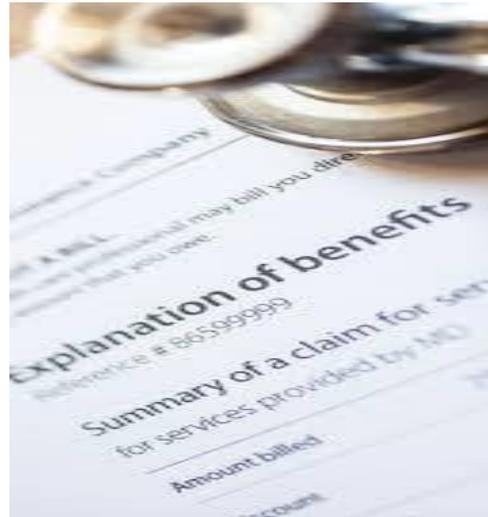


When Is the Primary EOB Required for TPL Insurance – Commercial ?

EOB needed:

- When the third-party liability (TPL) carrier has denied the service as noncovered
- When TPL carrier has applied the entire amount to the copay, coinsurance, or deductible; and no payment is made

Explanation of Benefits



EOB not needed:

- The primary insurance *COVERS* the service and has *PAID* on the claim
- Actual dollars were received

Other Insurance Third Party Liability Header

Claim Information

Claim Header Instructions

Hospital From Date	<input type="text"/>	Hospital To Date	<input type="text"/>
Date Type	<input type="text" value="v"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text" value="v"/>	Authorization Number	<input type="text"/>
*Patient Number	<input type="text"/>	Special Program	<input type="text" value="v"/>
Medical Record Number	<input type="text"/>		

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

*Does the provider accept assignment for claim processing? Yes No Clinical Lab Services Only

*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

IMPORTANT – If the primary insurance does not cover the services rendered, do **NOT** check the *Include Other Insurance* box

Other Insurance Third Party Liability Header

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1				\$25.00	-	Remove

Click to add a new other insurance. 

[Back to Step 1](#) [Continue](#) [Cancel](#)

- If the primary insurance is listed, click on the line-item number to open the window
- If primary insurance isn't listed, click “+” to add a new other insurance

Other Insurance Third Party Liability Header

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
<input type="checkbox"/> Click to collapse.						
	*Carrier Name	*Carrier ID				
	*Policy Holder Last Name		*First Name		MI	
	Policy Holder Address					
	City	State	ZIP Code		Country Code	
	*Policy ID		SSN			
	*Relationship to Patient		*Claim Filing Code			
	Group ID		Policy Name			
	TPL/Medicare Paid Amount	\$25.00	Paid Date			
	Claim ID		Authorization Number			
	Referral Number					
	<input type="button" value="Add"/>	<input type="button" value="Cancel"/>				

- 11-Other Non-Federal Programs
- 12-Preferred Provider Organization (PPO)
- 13-Point of Service (POS)
- 14-Exclusive Provider Organization (EPO)
- 15-Indemnity Insurance
- 16-Health Maintenance Organization (HMO) Medicare Risk
- 17-Dental Maintenance Organization
- AM-Automobile Medical
- BL-Blue Cross/Blue Shield
- CH-Champus
- CI-Commercial Insurance Co.**
- DS-Disability
- FI-Federal Employees Program
- HM-Health Maintenance Organization
- LM-Liability Medical
- MA-Medicare Part A
- MB-Medicare Part B
- OF-Other Federal Program
- TV-Title V

The TPL/Medicare Paid Amount field does not have an asterisk, but it is a required field

Other Insurance Third Party Liability Header

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1				\$25.00	-	Remove

Click to add a new other insurance.

[Back to Step 1](#) [Continue](#) [Cancel](#)



- After you save and see the information in the *Other Insurance Details* window, click **Continue**

Other Insurance Third Party Liability Detail

Service Details -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action	
<div style="border: 1px solid #ccc; padding: 5px;"> [-] Click to collapse. </div>								
	*From Date <input type="text" value="07/09/2019"/>	To Date <input type="text" value="07/09/2019"/>	*Place of Service <input type="text" value="11-Office"/>	*Procedure Code <input type="text" value="99213"/>	*Diagnosis Pointers <input type="text" value="1"/>			
	Modifiers <input type="text"/>		<input type="text"/>		<input type="text"/>			
	Charge Amount <input type="text" value="\$125.00"/>	*Units <input type="text" value="1.00"/>	*Unit Type <input type="text" value="Unit"/>	EPSDT <input type="checkbox"/>	Family Plan <input type="checkbox"/>	EMG <input type="checkbox"/>		
	Rendering Provider ID <input type="text"/>	ID Type <input type="text"/>	Rendering Taxonomy <input type="text"/>					
	Line Item Control# <input type="text"/>							
NDC for Service Detail +								
Note for Service Detail +								

- Click on the Service Detail line and complete the required fields
- Click **Add**
- Service Detail line will collapse



Other Insurance Third Party Liability Detail

Service Details							
Select the row number to edit the row. Click the Remove link to remove the entire row.							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	07/09/2019	07/09/2019	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$125.00	1.00 Unit	Remove
+ Click to add service detail.							

- Click the **1** for the service detail to open the *Other Insurance for Service Detail* window

Other Insurance Third Party Liability Detail

Other Insurance for Service Detail -

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Carrier ID	TPL/Medicare Paid Amount	Paid Date	Action
<input type="checkbox"/> Click to collapse.				
→	* Other Carrier <input style="width: 100%;" type="text"/>	* TPL/Medicare Paid Amount <input style="width: 100%;" type="text" value="\$25.00"/>	* Paid Date <input style="width: 100%;" type="text" value="08/19/2019"/>	<input type="button" value="Add"/> <input type="button" value="Cancel"/>

NDC for Service Detail +

Note for Service Detail +

- Use the drop-down menu to choose the insurance that was added at the header level, then add the payment received for that detail line and date of primary EOB
- Click **Add** and then **Save** to collapse the service detail line

*Red asterisks indicate required fields



Other Insurance

Third Party Liability Additional Details

Service Details							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	07/09/2019	07/09/2019	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$125.00	1.00 Unit	Remove
2	07/09/2019	07/09/2019	11-Office	94160-VITAL CAPACITY SCREENING	\$150.00	1.00 Unit	Remove
<input type="button" value="+"/> Click to add service detail.							

- Repeat these steps for EACH detail line to report the payment for each detail individually

When is the Primary Medicare or Medicare Replacement Plan EOB Required?

EOB needed:

- Only when Medicare or the Medicare Replacement Plan denies the service
(If Replacement Plan EOB is required, must write **Medicare Replacement Plan** on EOB)

Explanation of Benefits



EOB not needed:

The Medicare or Medicare Replacement Plan covers the service:

- Actual dollars were received
- Zero-paid claim
 - Entire
 - Partial amount was applied to deductible, coinsurance, or copay

A zero-paid claim IS NOT a denied claim

Medicare or Medicare Replacement Plan Header

Claim Information

Claim Header Instructions

Hospital From Date	<input type="text"/>	Hospital To Date	<input type="text"/>
Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text"/>	Authorization Number	<input type="text"/>
*Patient Number	<input type="text"/>	Special Program	<input type="text"/>
Medical Record Number	<input type="text"/>		

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

*Does the provider accept assignment for claim processing? Yes No Clinical Lab Services Only

*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**

IMPORTANT – If Medicare does not cover the services, do not check the “Include Other Insurance” box. The claim is not a crossover claim.



Medicare or Medicare Replacement Plan Header

Other Insurance Details [-]

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

Refresh Other Insurance

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
<u>1</u>						Remove

Click to add a new other insurance.

Back to Step 1 **Continue** **Cancel**

- If Medicare and/or Replacement Plan is listed, click **1**
- If Medicare and/or Replacement Plan is not listed, click on the **“+”** sign to add the insurance payment to be reported

Medicare or Medicare Replacement Plan Header

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
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Click to collapse.

*Carrier Name *Carrier ID

*Policy Holder Last Name *First Name MI

Policy Holder Address

City State ZIP Code Country Code

*Policy ID SSN

*Relationship to Patient *Claim Filing Code

Group ID Policy Name

TPL/Medicare Paid Amount \$30.00

Claim ID

Referral Number

Medicare Replacement Plan = 16
Traditional Medicare = MB

- 11-Other Non-Federal Programs
- 12-Preferred Provider Organization (PPO)
- 13-Point of Service (POS)
- 14-Exclusive Provider Organization (EPO)
- 15-Indemnity Insurance
- 16-Health Maintenance Organization (HMO) Medicare Risk
- 17-Dental Maintenance Organization
- AM-Automobile Medical
- BL-Blue Cross/Blue Shield
- CH-Champus
- CI-Commercial Insurance Co.
- DS-Disability
- FI-Federal Employees Program
- HM-Health Maintenance Organization
- LM-Liability Medical
- MA-Medicare Part A
- MB-Medicare Part B
- OF-Other Federal Program
- TV-Title V

The TPL/Medicare Paid Amount field does not have an asterisk but is a required field

Medicare or Medicare Replacement Plan Header

Other Insurance Details -

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	Medicare	08102		\$30.00	-	Remove

Click to add a new other insurance.

Back to Step 1

Continue

Cancel

- After you click **Save**, the system defaults back to the **Other Insurance Details** window
- Click on the insurance line number again to add the coinsurance and deductible information in the **Claim Adjustment Details** window



Medicare or Medicare Replacement Plan Header

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	Action
---	-----------------------------	-------------	-------------------	-------	--------

Click to collapse.

* Claim Adjustment Group Code

* Reason Code

* Adjustment Amount Adjusted Units

Click to add a new other insurance.

Reason Codes:
1 Deductible
2 Coinsurance
3 Copayment

- Click **Add** after all information has been entered
- Adjustment Amount is the Patient Responsibility amount

Medicare or Medicare Replacement Plan Header

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	Medicare	08102		\$30.00	-	Remove

Carrier Name: Carrier ID:

*Policy Holder Last Name: *First Name: MI

Policy Holder Address:

City: State: ZIP Code: Country Code:

*Policy ID: SSN:

*Relationship to Patient: *Claim Filing Code:

Group ID: Policy Name:

TPL/Medicare Paid Amount: Paid Date:

Claim ID:

Referral Number: Authorization Number:

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	Action
1	PR-Patient Responsibility	1-Deductible Amount	\$15.00		Remove

Click to add a new claim adjustment.



Click to add a new other insurance.

- If the member has more than one Patient Responsibility, click the “+” sign to add new claim adjustment
- After *Claim Adjustment Details* window is completed, click **Save** then click **Continue**



Medicare or Medicare Replacement Plan Detail

Service Details							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
<u>1</u>	07/09/2019	07/09/2019	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$125.00	1.00 Unit	Remove
<u>2</u>	07/09/2019	07/09/2019	11-Office	94160-VITAL CAPACITY SCREENING	\$150.00	1.00 Unit	Remove
<input type="checkbox"/> Click to add service detail.							

- Click on the Service Details line
- The Service Detail line will expand
- Enter the Other Insurance for Service Detail information and click **Add**



Medicare or Medicare Replacement Plan Detail

Service Details -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	07/09/2019	07/09/2019	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$125.00	1.00 Unit	Remove

***From Date** **To Date** ***Place of Service**

***Procedure Code** ***Diagnosis Pointers**

Modifiers

Charge Amount ***Units** ***Unit Type** **EPSDT** **Family Plan** **EMG**

Rendering Provider ID **ID Type** **Rendering Taxonomy**

Line Item Control#

Other Insurance for Service Detail -

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Carrier ID	TPL/Medicare Paid Amount	Paid Date	Action
Click to collapse.				
	<input type="text" value="08102-Medicare"/>	<input type="text" value="\$30.00"/>	<input type="text" value="08/19/2019"/>	

- Use the drop-down menu to choose the insurance that was added at the header level, then add the payment received for that detail line and date of primary EOB
- Click **Add**

***Red asterisks** indicate required fields



Medicare or Medicare Replacement Plan Claim Adjustment Details

Other Insurance for Service Detail

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Carrier ID	TPL/Medicare Paid Amount	Paid Date	Action
1	08102	\$30.00	07/09/2019	Remove

*Other Carrier: 08102-Medicare

*TPL/Medicare Paid Amount: \$30.00 *Paid Date: 07/09/2019

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	Action
	PR-Patient Responsibility	1	15.00		

Click to collapse.

*Claim Adjustment Group Code: PR-Patient Responsibility

*Reason Code: 1

*Adjustment Amount: 15.00 Adjusted Units:

Add **Cancel**

Save **Cancel**

Click to add a new other insurance.

- Click #1 to open *Claim Adjustment Details* window
- Use the drop-down menu to choose PR – Patient Responsibility
- Choose appropriate reason code
- Enter amount of deductible/coinsurance/copay
- Click **Add** and **Save**



Medicare or Medicare Replacement Plan Additional Details

Service Details -							
Select the row number to edit the row. Click the Remove link to remove the entire row.							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	07/09/2019	07/09/2019	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$125.00	1.00 Unit	Remove
2	07/09/2019	07/09/2019	11-Office	94160-VITAL CAPACITY SCREENING	\$150.00	1.00 Unit	Remove
<input type="checkbox"/> Click to add service detail.							

- Repeat these steps for EACH detail line to report the payment for each detail individually

Adding Claim Attachments

When primary EOB is required, click the “+” sign.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
*Transmission Method FT-File Transfer					
*Upload File Choose File No file chosen					
*Attachment Type					
BT-Blanket Test Results					
CB-Chiropractic Justification					
CK-Consent Form(s)					
CT-Certification					
D2-Drug Profile Document					
DA-Dental Models					
DB-Durable Medical Equipment Prescription					
DG-Diagnostic Report					
DJ-Discharge Monitoring Report					
DS-Discharge summary					
EB-Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)					
HC-Health Certificate					
HB-Health Clinic Records					

- Search for the file from the documents saved on the computer
- Attachment size limit is:
5 Megabyte total allowed
- Document types allowed: PDF, BMP, GIF, JPG/JPEG, PNG, and TIFF/TIF

Submit the Claim

Service Details							
Select the row number to edit the row. Click the Remove link to remove the entire row.							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	07/09/2019	07/09/2019	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$125.00	1.00 Unit	Remove
2	07/09/2019	07/09/2019	11-Office	94160-VITAL CAPACITY SCREENING	\$150.00	1.00 Unit	Remove
<input type="checkbox"/> Click to add service detail.							
Attachments							
Click the Remove link to remove the entire row.							
#	Transmission Method	File	Control #	Attachment Type	Action		
<input type="checkbox"/> Click to add attachment.							
Claim Note Information							
Click the Remove link to remove the entire row.							
#	Note Reference Code	Note Text					Action
<input type="checkbox"/> Click to add a new claim note							
Back to Step 1				Back to Step 2		Submit	
						Cancel	

- Click **Submit**



Confirm

Service Details

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units
<u>1</u>	07/09/2019	07/09/2019	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$125.00	1.00 Unit
<u>2</u>	07/09/2019	07/09/2019	11-Office	94160-VITAL CAPACITY SCREENING	\$150.00	1.00 Unit

No Other Insurance Details exist for this claim

No Attachments exist for this claim

No Claim Notes exist for this claim

[Back to Step 1](#)

[Back to Step 2](#)

[Back to Step 3](#)

[Print Preview](#)

[Confirm](#)

[Cancel](#)

- Click **Confirm**

Claim Status and Claim ID

INDIANA MEDICAID *for Providers*

Contact Us | FAQs | Logout

My Home Eligibility Claims Care Management Resources Switch Provider

Claims > Claim Receipt

Delegate for Role IDs

Submit Professional Claim: Confirmation

Professional Claim Receipt

Your Professional Claim was successfully submitted. The claim status is Finalized

The Claim ID is

Payment/Denied

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**

Attachment and/or Claim Note may cause the claim to be:

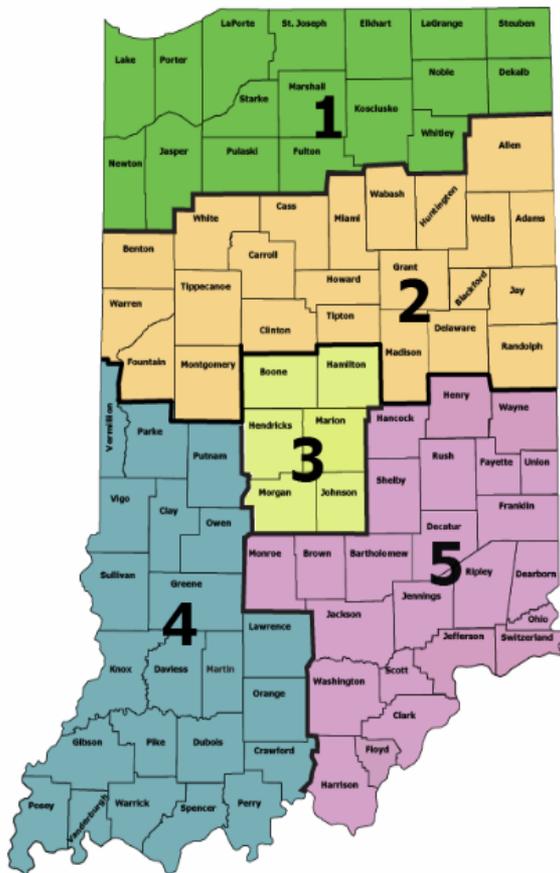
Pending/In Process

Helpful Tools



Helpful Tools

Provider Relations Consultants



REGION	FIELD CONSULTANT	EMAIL	TELEPHONE	COUNTIES SERVED
Illinois Michigan	1 Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	DeKalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley Chicago, Watseka Sturgis
Illinois	2 Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountain, Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White Danville
	3 Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boonem, Hamilton, Hendricks, Johnson, Marion, Morgan
	4 Ken Guth	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderbirgh, Vermillion, Vigo, Warrick Owensboro
Kentucky	5 Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Hancock, Henry, Jackson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne Louisville Cincinnati, Harrison, Hamilton, Oxford
	Judy Green		(317) 488-5026	All other out of state areas not previously listed
Team Lead	Jenny Atkins		(317) 488-5032	

Helpful Tools

IHCP website at in.gov/medicaid/providers:

- *IHCP Provider Reference Modules*
- *Medical Policy Manual*
- Contact Us – Provider Relations Field Consultants

Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m.
Eastern Time
- 1-800-457-4584

Secure Correspondence:

- Via the Provider Healthcare Portal
 - *(After logging in to the Portal, click the **Secure Correspondence** link to submit a request)*



Questions

Please review your schedule for the next session
you are registered to attend



Session Survey

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.



<https://tinyurl.com/fssa1057>

