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2022 IHCP Works Seminar
CMS-1500 Claims

Presented By: Chris Bryant

Providing health coverage to Indiana families since 1994

Agenda

- About MDwise
- CMS-1500 Claim Form (Professional Claim)
- Claims Submission
- Claims Adjustments
- Claims Disputes
- Common Barriers
- Resources & Contacts
- Questions

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About MDwise

Our Mission

To enhance client satisfaction and lower total health care costs by improving the health status of members through the most efficient provision of quality health care services.

- MDwise is local and Indiana's only non-profit, provider-sponsored health plan
- Owned by McLaren Health Care Corporation, a provider-owned, not-for-profit integrated health system with multi-state experience committed to better serving Hoosier families
- MDwise administers Medicaid and Medicare programs throughout Indiana to ensure all families receive high-quality and affordable health care
- MDwise has a large network of doctors, specialists and hospitals throughout Indiana

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CMS-1500 Claim Form (Professional Claim)

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Who Can Bill on a CMS-1500 Form

The following provider types can submit claims via Paper on a CMS-1500 or Electronically - 837P (HIPPA compliant professional):

- Clinics
- Physician – Doctor of medicine (MD) and doctor of osteopathy (DO)
- Physician assistant
- Podiatrist
- Advanced practice registered nurse (APRN)
- Optometrist
- Durable medical equipment (DME) and home medical equipment (HME)

Services Billed on CMS-1500 Claim Form

Services that can billed on the CMS-1500 claim form, or the 837P electronic transaction can be found in the IHCP Claim Submission and Processing Module.

CMS-1500 Billing Requirements

The following must be included on all claims:

- Billing National Provider Identifier (NPI) number
- Service Location Address
- Tax Identification Number (TIN)
- Taxonomy Code
- Rendering Provider Name
- Rendering NPI
- Rendering Address

Note: Providers must be enrolled with Indiana Medicaid at https://www.in.gov/medicaid/providers/provider-enrollment/

CMS-1500 Billing Requirements

Field 24J: Rendering provider NPI

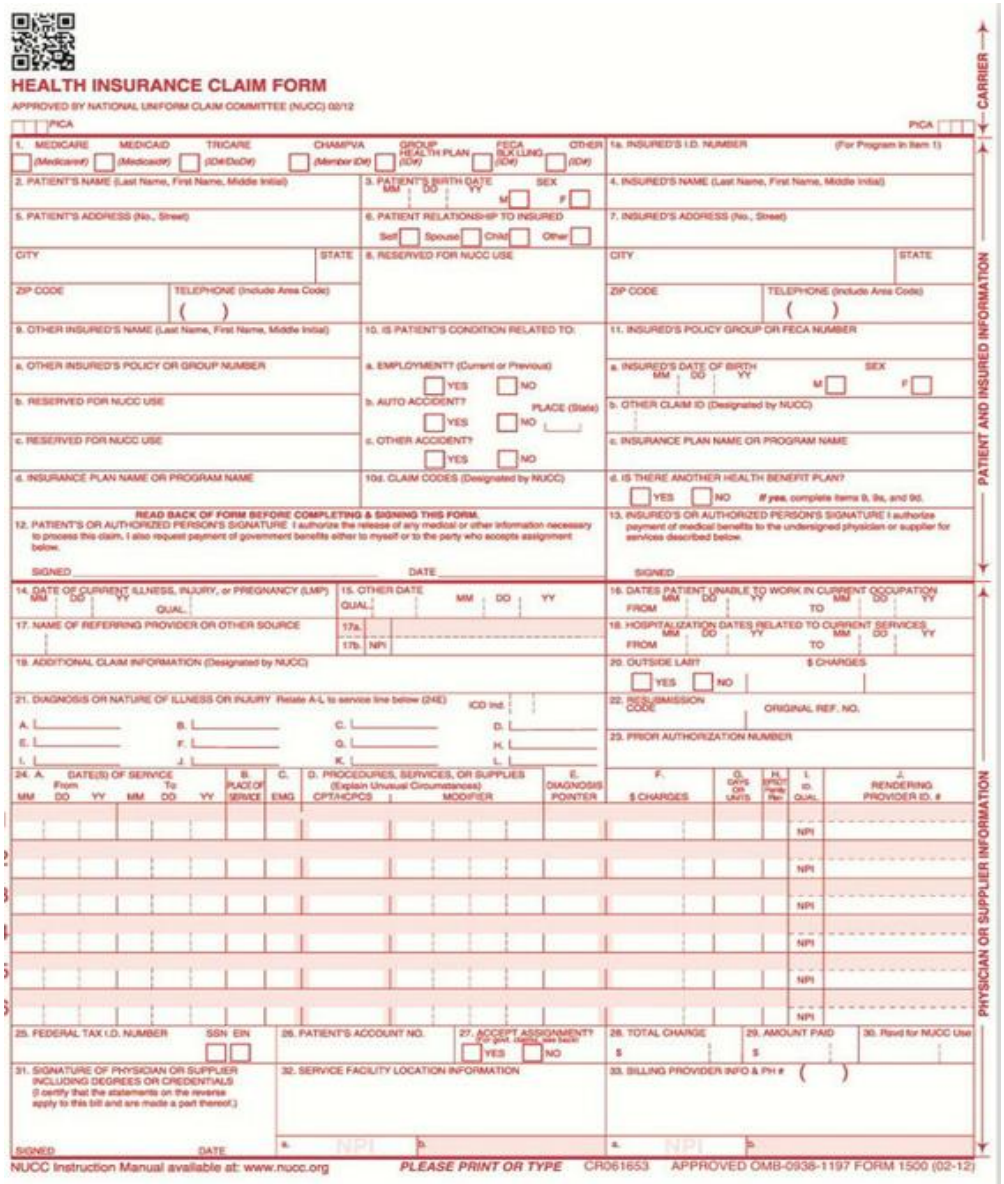
Field 33: Group/Billing provider service location address with complete ZIP code+4 **(No P.O. Box)**

- Must match the service location address currently on file with IHCP where the service was rendered
- Please refer to IHCP Banner BR201820

Field 33a: Group billing provider NPI

Field 33b: Group billing taxonomy code

CMS-1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
											NPI
											NPI
											NPI
											NPI
											NPI
											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

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Tips for Preparing CMS-1500 Claim Form

- Ensure that all data is entered correctly and accurately in the correct fields
- Enter insurance information including the patient's name exactly as it appears on the insurance card
- MDwise requires Primary COB on the line level
- Use only the physical address for the service facility location field

Claims Submission

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MDwise Initial Claims Submission

Submit via Paper and Electronically

Medical and Behavioral Health

Paper claims

MDwise/McLaren Health Plans
P.O. Box 1575
Flint, MI 48501

Electronic claims

Hoosier Healthwise EDI/Payer ID: 3519M
Healthy Indiana Plan EDI/Payer ID: 3135M

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Benefits of Electronic Claims Submission

- Expedites processing turnaround and potential payment timeframes
- Reduces operation costs (no printing or postage costs)
- Increases accuracy of data and efficient information delivery
- Reduces claim delays because errors can be corrected and resubmitted electronically
- Allows for tracking and monitoring claim progress
- Fastest way for clean claims to be considered for reimbursement

Note: If you experience issues submitting claims electronically, please contact your clearinghouse first.

Paper Claims Submission Tips

- Submissions must be done using the most current form version as designated by CMS
- MDwise does not accept handwritten claims
- Use only original claim forms (red and white)
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps

Note: Ensure printing is aligned correctly so that all data is contained within the corresponding boxes on the form.

Claims with Coordination of Benefits (COB)

If member has primary coverage:

- Submit detail primary Explanation of Payment (EOP) with Claim Adjustment Request Form for data entry.

If member does not have primary coverage:

- Submit Claim Adjustment Request Form with proof of other insurance being termed for COB update and claim reprocess.

Claim Submission Timelines

Type	Days Allowed
Contracted	90 calendar days from the date of service
Secondary	90 calendar days from the date of the primary explanation of payment (EOP)
Corrected	90 calendar days from the date of the EOP
Newborn	365 days from the date of service within the first 30 days of life
Non-Contracted	180 calendar days from the date of service

MDwise Claims Turnaround Timeline

Processing time:

- 21 days for electronic clean claims
- 30 days for paper clean claims

Note: Please allow claims to be processed during the timeline above prior to resubmitting.

Denials versus Rejected Claims

- **Rejected** claims are returned to the provider or EDI vendor without registering in the claim processing system
  - Provider must resubmit the claim within the timely filing limit
- **Rejected** claims do not extend the timely filing limit.
  - Contracted providers have 90 days from the date of service
- **Rejected** claims can not be reprocessed, adjusted, disputed or appealed
- **Denied** claims will include an EOP with a denial code and description.
  - If determined denied in error, a claims adjustment or dispute can be submitted

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Claims Adjustments

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When to Submit a Claim Adjustment Request

- After contacting our Provider Customer Service Unit (PCSU) at 1-833-654-9192 without a resolution
- If you feel your claim has been denied or paid in error and want your claim reconsidered
- If the claim paid at an inappropriate rate
- To submit attachments missing from original claim submission

Note: Claims Adjustment Request Form should be submitted before the Claim Dispute process

Provider Claim Adjustment Request Form

Provider Claim Adjustment Request Form Directions

When To Use the Provider Claim Adjustment Form

A provider may submit a Provider Claim Adjustment Form if you believe a claim has been adjudicated incorrectly or a service denied inappropriately.

Claim Adjustment Process	Time Frames
Within 90 calendar days from the date of the MDwise explanation of payment (EOP) provider should complete the Claim Adjustment Form and attach a copy of the corrected claim, and/or any supporting documentation for the adjustment. **Send to:** Email: MDwiseClaims@mclaren.org Fax: 833-540-8649	Claim Adjustment Form must be received within 90 calendar days of the most recent MDwise explanation of payment (EOP).

Process Clarification

The Claims Adjustment process is not available to a provider if the Dispute Process has been used and the provider was not satisfied with the outcome.

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Provider Claim Adjustment Request Form

MDwise Provider Claim Adjustment Request Form

WHEN TO USE THIS FORM:

A **Claim Adjustment** is a request for payment reconsideration for a paid or denied claim. Any claim for which an Explanation of Payment (EOP) was issued that was paid inappropriately, or was denied, can be resubmitted on a paper claim (not EDI) with supporting documentation as an adjustment.

Claim Adjustment Request Time Frame - All claim adjustment inquiries and requests must be made to MDwise within 90 calendar days of the most current MDwise EOP. Any inquiry or request made after 90 calendar days will not be given consideration. The acknowledgement of receipt date will only be considered when a completed request form and supporting documentation is received by MDwise.

COMPLETE THE FOLLOWING REQUIRED INFORMATION:

Member Name: _____ MID #: _____

MDwise Claim #: _____ DOS: _____ (dates of service 1/1/19 and AFTER)

Provider Name: _____ Tax ID#: _____

Office Contact: _____ Rendering NPI #: _____

Date *Provider Claim Adjustment Form* Submitted: _____ Phone #: _____

Email: _____ Fax #: _____

Reason for Request (please check appropriate box & provide description below):

For a correction to a previously submitted claim:

- ☐ Date of Service
- ☐ Diagnosis Code
- ☐ Modifier
- ☐ Place of Service
- ☐ Procedure Code
- ☐ Provider/Tax ID
- ☐ Other: _____

For reconsideration: (supporting documentation required)

- ☐ Service denied for lack of authorization (attach copy of authorization information or number)
- ☐ Service denied as other insurance primary (COB) (attach copy of primary EOB)
- ☐ Service denied as a duplicate (attach documentation)

Send this completed Provider Claim Adjustment Request Form along with a copy of the claim form and/or any supporting documentation to:

Email: MDwiseClaims@mclaren.org
Fax: 833-540-8649

For questions regarding the Provider Claims Adjustment Process, call Customer Service at 833-654-9192.

G-3245 Beecher Road • Flint, Michigan • 48532 | Phone: 888-327-0671 | Fax: 877-502-1567 | McLarenHealthPlan.org

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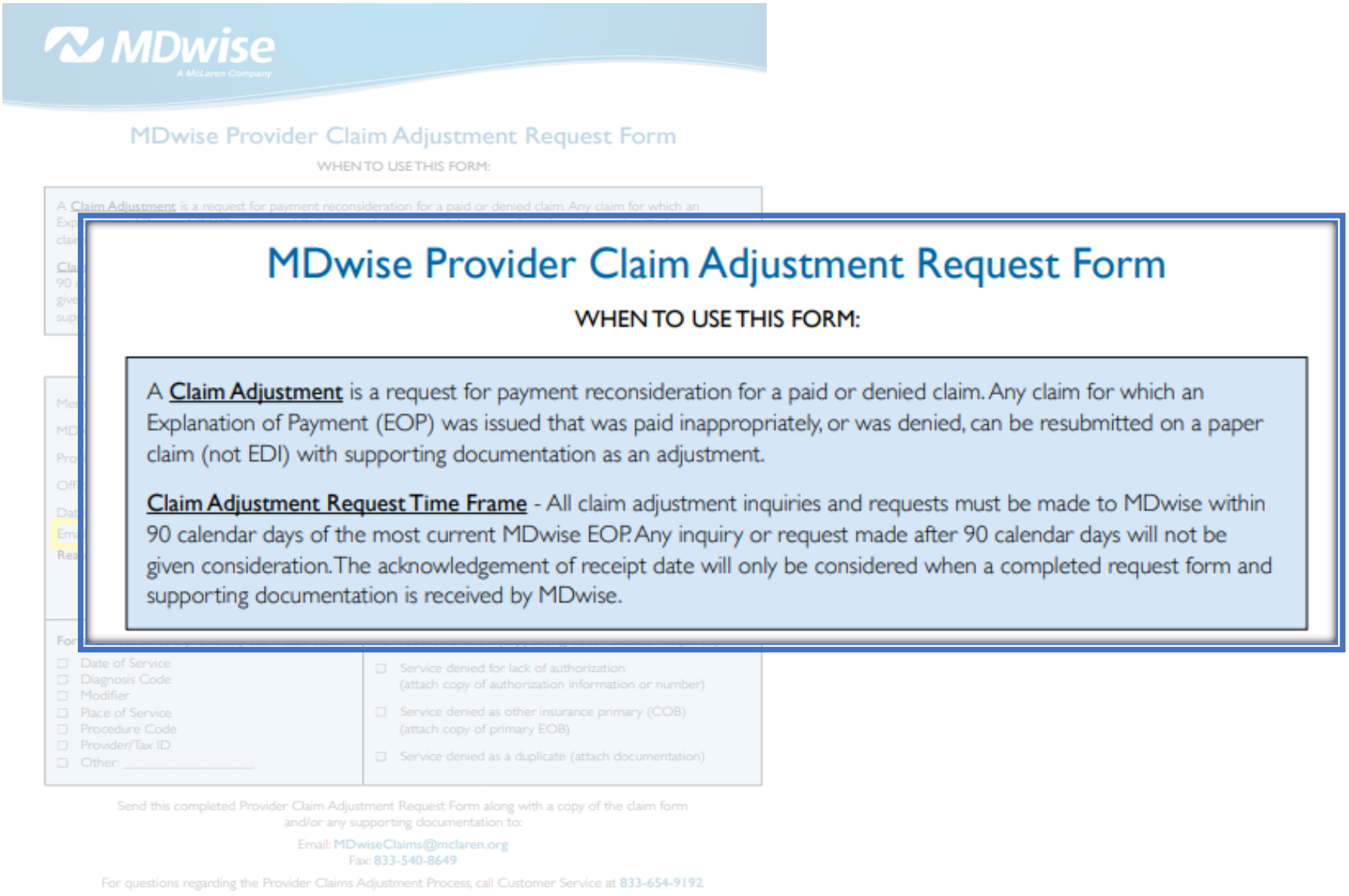
Provider Claim Adjustment Request Form



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MDwise Provider Claim Adjustment Request Form

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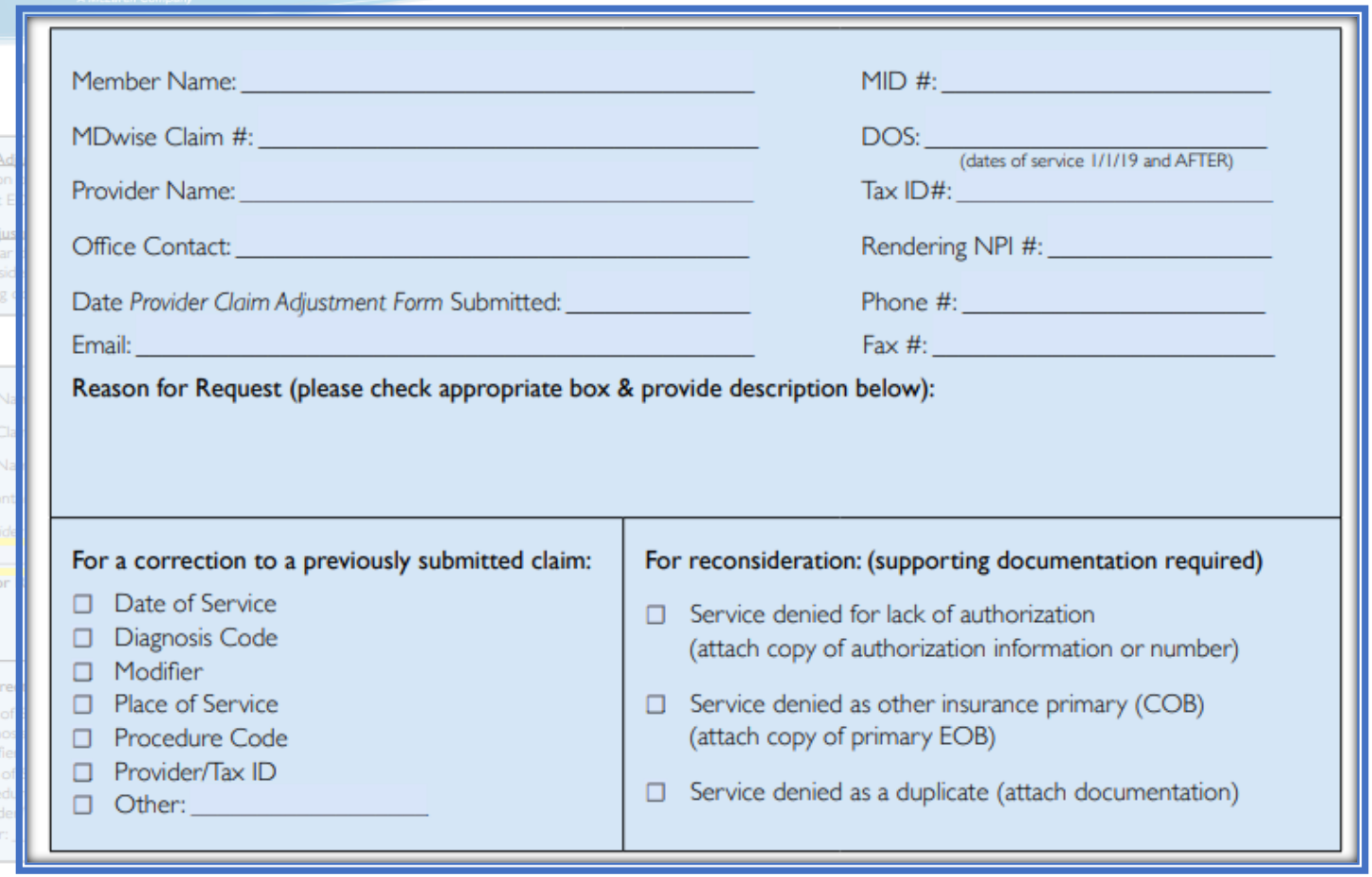
Provider Claim Adjustment Request Form



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Member Name: _____ MID #: _____

MDwise Claim #: _____ DOS: _____
(dates of service 1/1/19 and AFTER)

Provider Name: _____ Tax ID#: _____

Office Contact: _____ Rendering NPI #: _____

Date *Provider Claim Adjustment Form* Submitted: _____ Phone #: _____

Email: _____ Fax #: _____

Reason for Request (please check appropriate box & provide description below):

For a correction to a previously submitted claim:

- ☐ Date of Service
- ☐ Diagnosis Code
- ☐ Modifier
- ☐ Place of Service
- ☐ Procedure Code
- ☐ Provider/Tax ID
- ☐ Other: _____

For reconsideration: (supporting documentation required)

- ☐ Service denied for lack of authorization (attach copy of authorization information or number)
- ☐ Service denied as other insurance primary (COB) (attach copy of primary EOB)
- ☐ Service denied as a duplicate (attach documentation)

Send this completed Provider Claim Adjustment Request Form along with a copy of the claim form and/or any supporting documentation to:

Email: MDwiseClaims@mclaren.org
Fax: 833-540-8649

For questions regarding the Provider Claims Adjustment Process, call Customer Service at 833-654-9192.

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Where to Submit a Claim Adjustment Request

The completed Provider Claim Adjustment Request Form, a copy of the original claim and/or any supporting documentation should be sent to one of the following:

MDwiseClaims@mclaren.org

OR

Fax request: 1-833-540-8649

Note:

1. Questions on the claim adjustment process and status, call MDwise PCSU at 1-833-654-9192.
2. Please add required attachments when submitting a Claim Adjustment Request Form.

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Provider Claim Adjustment Time Frame

- Form must be received **within 90 calendar days** of the most recent MDwise EOP
- Any inquiry or request made after 90 calendar days will not be considered
- Only one claim per Provider Claims Adjustment Request Form
- After a completed request form and supporting documents are received, an acknowledgement receipt date will be provided

Process Clarification: The Claims Adjustment process is not available to a provider if the Dispute Process has been used and the provider was not satisfied with the outcome.

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Claims Disputes

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When to Submit a Claims Dispute

Examples of denials that may constitute a dispute include:

- Timely filing
- Coding issues
- Prior authorization

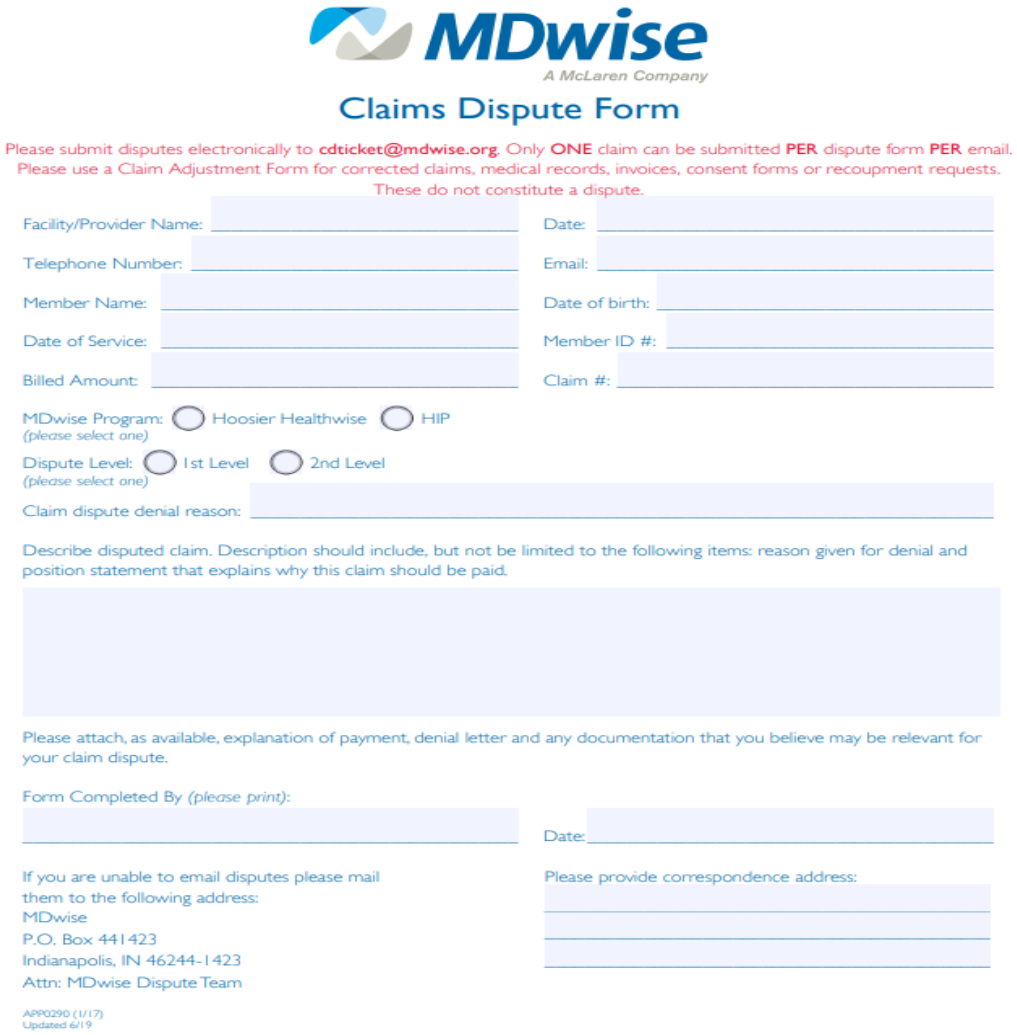
The following DO NOT constitute a dispute:

- New claims
- Corrected claims
- Medical records
- Attachments (consent forms, invoices)
- Recoupments

Note: Please refer to the Claims Adjustment Request Form for issues that do not constitute a dispute.

Claim Dispute Form

Claims Dispute Form



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Claims Dispute Form

Please submit disputes electronically to **cdticket@mdwise.org**. Only **ONE** claim can be submitted **PER** dispute form **PER** email.
Please use a Claim Adjustment Form for corrected claims, medical records, invoices, consent forms or recoupment requests.
These do not constitute a dispute.

Facility/Provider Name: _____ Date: _____

Telephone Number: _____ Email: _____

Member Name: _____ Date of birth: _____

Date of Service: _____ Member ID #: _____

Billed Amount: _____ Claim #: _____

MDwise Program: ◯ Hoosier Healthwise ◯ HIP
(please select one)

Dispute Level: ◯ 1st Level ◯ 2nd Level
(please select one)

Claim dispute denial reason: _____

Describe disputed claim. Description should include, but not be limited to the following items: reason given for denial and position statement that explains why this claim should be paid.

Please attach, as available, explanation of payment, denial letter and any documentation that you believe may be relevant for your claim dispute.

Form Completed By *(please print)*:

_____ Date: _____

If you are unable to email disputes please mail them to the following address:
MDwise
P.O. Box 441423
Indianapolis, IN 46244-1423
Attn: MDwise Dispute Team

Please provide correspondence address:

_____

_____

_____

APP0290 (1/17)
Updated 6/19

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Submitting a Claim Dispute Request

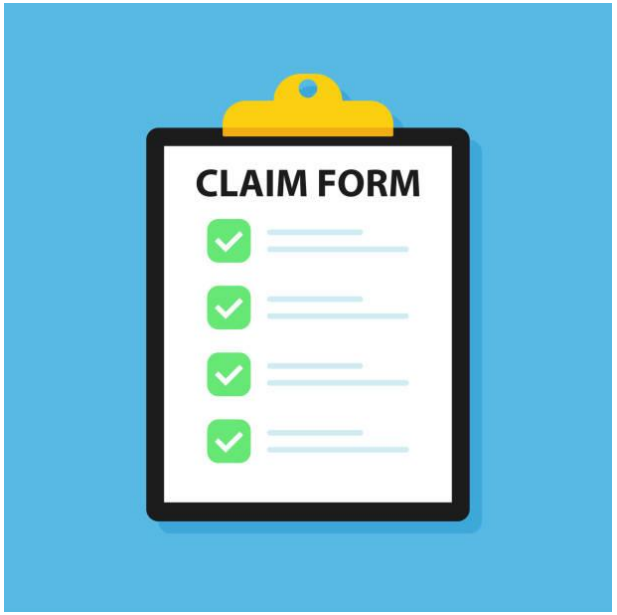
- All in- and out- of network providers have the right to dispute a claim decision or action
- Completely fill out the Claims Dispute Form
- Use a separate form for each dispute
- When submitting a dispute, providers should include
  - EOP
  - The dispute form
  - An explanation of the reason for disputing the claim

Where to Submit a Claims Dispute

Submit completed Claims Dispute Form via email to cdticket@MDwise.org. A return email will be issued with a tracking ticket number.

If email is unavailable, mail to:

MDwise
P.O. Box 441423
Indianapolis, IN 46244-1423
Attention: MDwise Dispute Team



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Claims Dispute Time Frame

- Providers must file their initial claim dispute **within 60 days of a claim's determination**
- Claim disputes are reviewed by individuals who were not involved in the original claim decision
- MDwise will review all disputes and respond to the provider within 30 calendar days
- If the original decision is upheld, the provider will be given information on how to file a second level dispute

CMS-1500 Claims Common Barriers

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CMS-1500 Claims – Common Barriers

- Coordination of Benefits (COB)
- Member Eligibility
- Authorization Denial
- Manufacture Suggested Retail Price (MSRP)/Cost Invoice
- Consent Form/Documentation
- Timely Filing

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Resources and Contact Information

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MDwise Billing Methods

Pharmacy Claims should be submitted to MedImpact

Pharmacy Claims
Electronic claims
BIN – 003585
PCN – ASPROD1
RX GROUP – MDW

MedImpact Customer Service for Hoosier Healthwise/HIP Prescribers, Members, and Pharmacies: 1-844-336-2677 (24 hours, 7 days per week).

Resources

Claims Page

https://www.mdwise.org/for-providers/claims

Claim Forms

https://www.mdwise.org/for-providers/forms/claims

- Claim Adjustment Request Form
- Claims Dispute Form
- Provider Refund Remittance Form
- Vision Eligibility Request Form

Claim Inquiries

- Providers can use myMDwise provider portal to quickly view the status of claims.

Resources

MDwise Manuals - https://www.mdwise.org/for-providers/manual-and-overview

IHCP Provider Modules - https://www.in.gov/medicaid/providers/provider-references/provider-reference-materials/ihcp-provider-reference-modules/

MDwise Claims: PCSU

1-833-654-9192

MDwise Member Customer Service

1-800-356-1204

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MDwise Provider Relations Team

Region 1
Robert Tanna
rtanna@mdwise.org
317-407-5910

Region 2
Amy Kerr
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317-741-4352

Region 3
Lauryn Gooch
lgooch@mdwise.org
317-460-3419

Region 4
Joy Diarra
jdiarra@mdwise.org
317-619-5622

Region 5
LeAnne Ramsey
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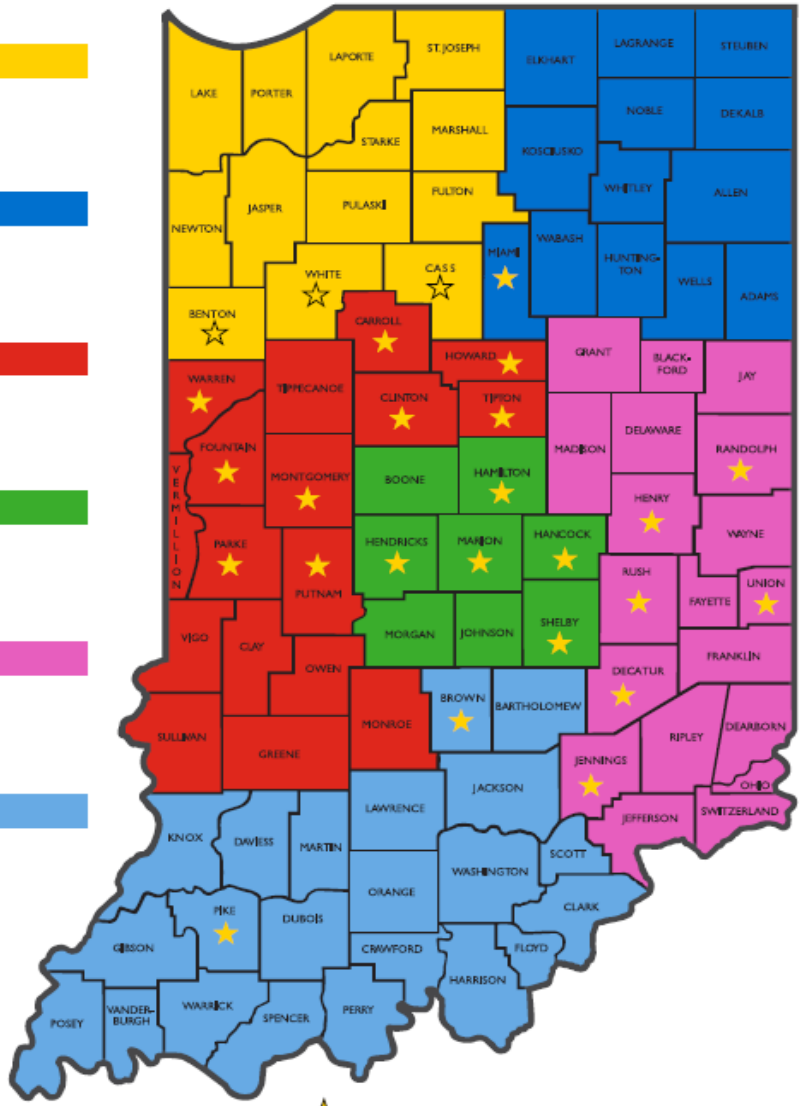
317-460-4697

Region 6
Chris Bryant
cbryant@mdwise.org
317-517-4776



Click here to find our map online.

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MDwise Provider Relations Team

PROVIDER GROUP REPRESENTATIVES

Tonya Trout

ttrout@mdwise.org
317-766-0505

Provider Groups

Ascension St. Vincent
Franciscan Alliance
Beacon
Union
Parkview
Home Health and Hospice
Skilled Nursing Facilities (SNFs)

LaToya Robertson

lrobertson@mdwise.org
317-552-8420

Provider Groups

Federally Qualified Health Centers (FQHCs)
Rural Health Center (RHCs)
Community Mental Health Centers (CMHCs)
Eskenazi Health

PROVIDER RELATIONS LEADERSHIP

Josh Burger

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317-460-4510

LaKisha Browder

Manager Provider Relations
lbrowder@mdwise.org
317-822-7298

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Thank you!

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QUESTIONS?

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