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2023 IHCP Works Seminar

CMS-1500 & UB-04 Claims

Presented By: Chris Bryant

Providing health coverage to Indiana families since 1994

Agenda

- About MDwise
- *CMS-1500* (Professional Claim)
- UB-04 (Institutional Claim)
- Claim Submission
- Claim Adjustments
- Claim Disputes
- Common Barriers
- Resources and Contacts
- Questions

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About MDwise

Our Mission

MDwise provides high-quality, affordable health care services and improves the well-being of our members by bringing together exceptional employees, community leaders and health care professionals.

- 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

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)

Note: Above List is not inclusive, refer to IHCP Claim Submission and Processing Module page 59-61 for full detailed list

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.

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CMS-1500 Billing Requirements

The following must be included in 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 by going to the IHCP module here.

CMS-1500 Billing Requirements

Field 24J: Rendering provider NPI

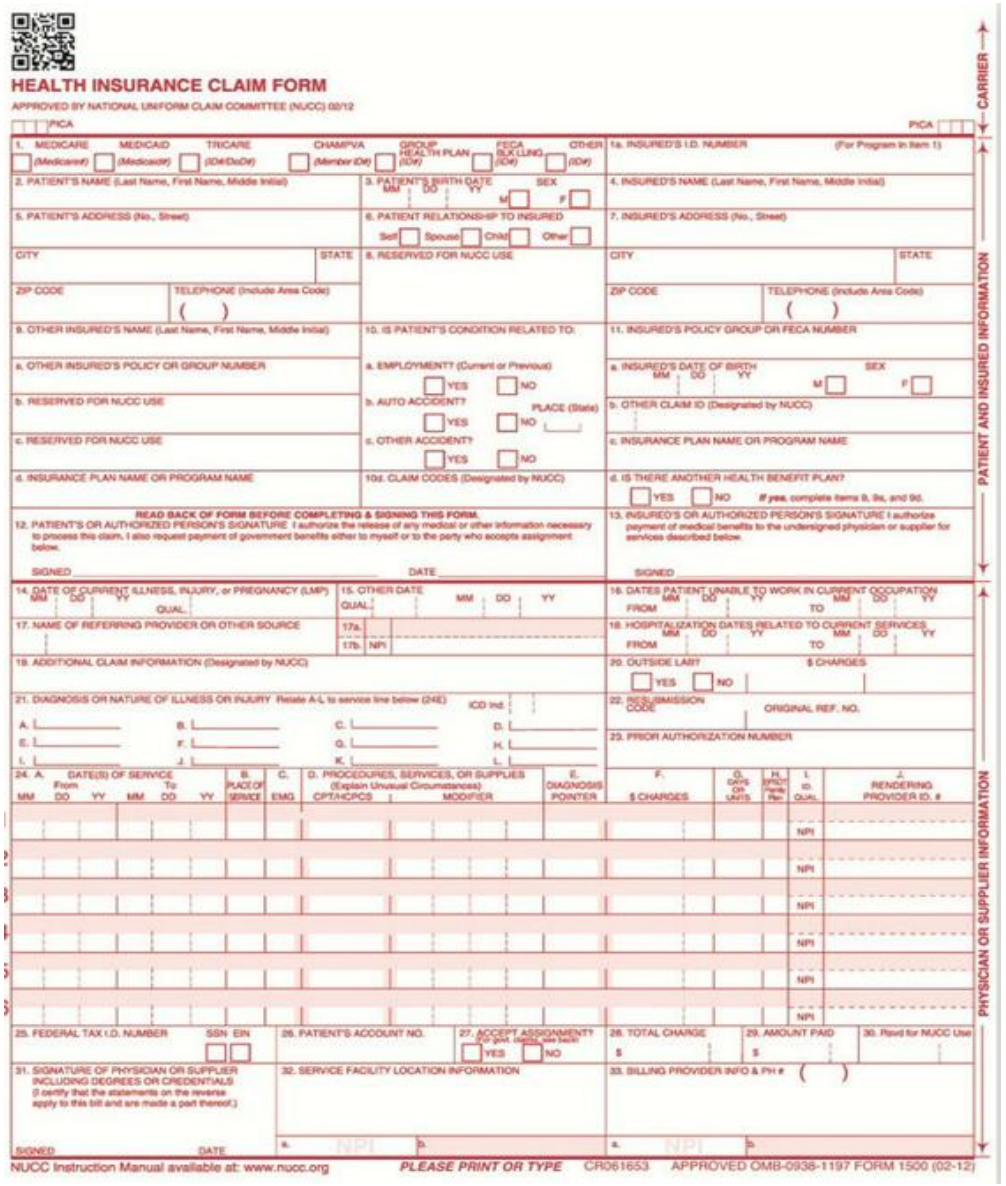
Field 33: Group/Billing provider service location address with complete ZIP code+4 **(No P.O. Box)**

- 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.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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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

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UB-04 Claim Form (Institutional Claim)

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Who Can Bill on a UB-04 Form?

The following provider types can submit claims via Paper on a UB-04 or Electronically via 837I (HIPPA compliant institutional):

- Hospital
- Ambulatory Surgical Center (ASC)
- Home Health Agency (HHA)
- Hospice
- Outpatient PT/OT/ST
- Rehabilitation Facility
- End-Stage Renal Disease (ESRD) Clinic
- Skilled Nursing Facilities (SNF)

Services Billed on UB-04 Claim Form

Services that can billed on the UB-04 claim form, or the 837I electronic transaction can be found on the IHCP Claim Submission and Processing Module.

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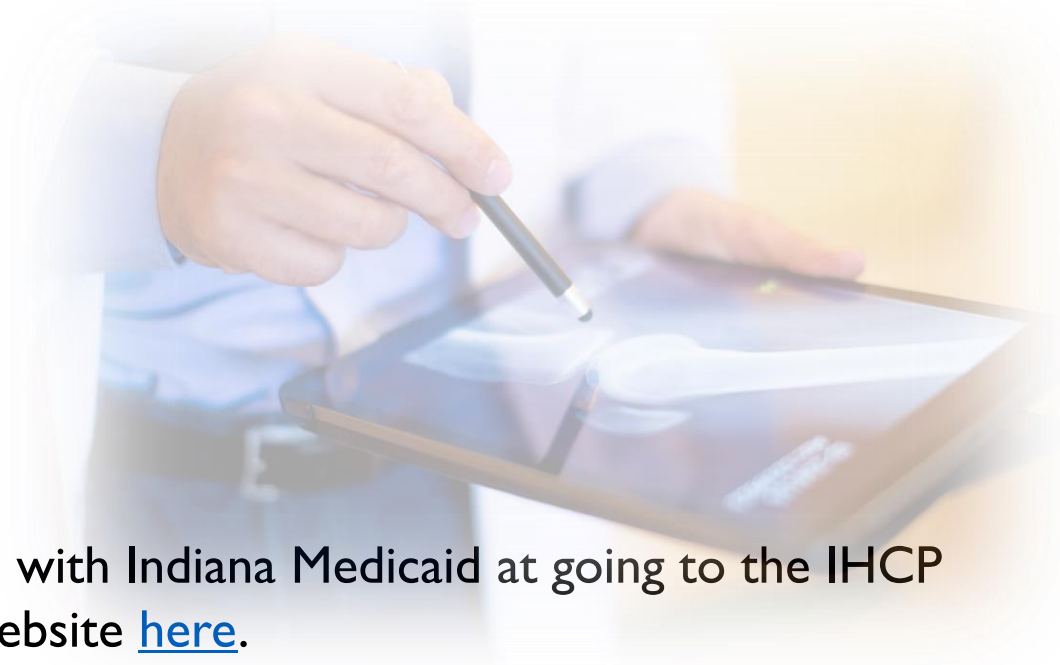
UB-04 Billing Requirements

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 going to the IHCP website here.

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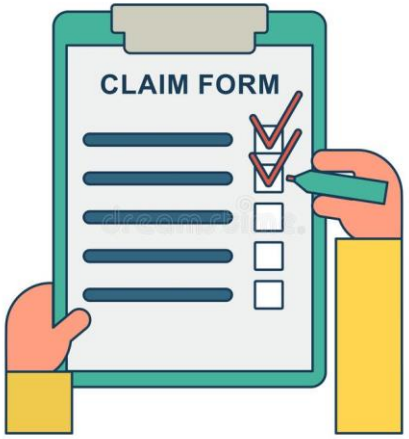
UB-04 Billing Requirements

- Field 1: Billing provider service location name, address and expanded ZIP Code+4
- Field 56: 10-digit NPI for the billing provider
- Field 81ccA: Billing taxonomy



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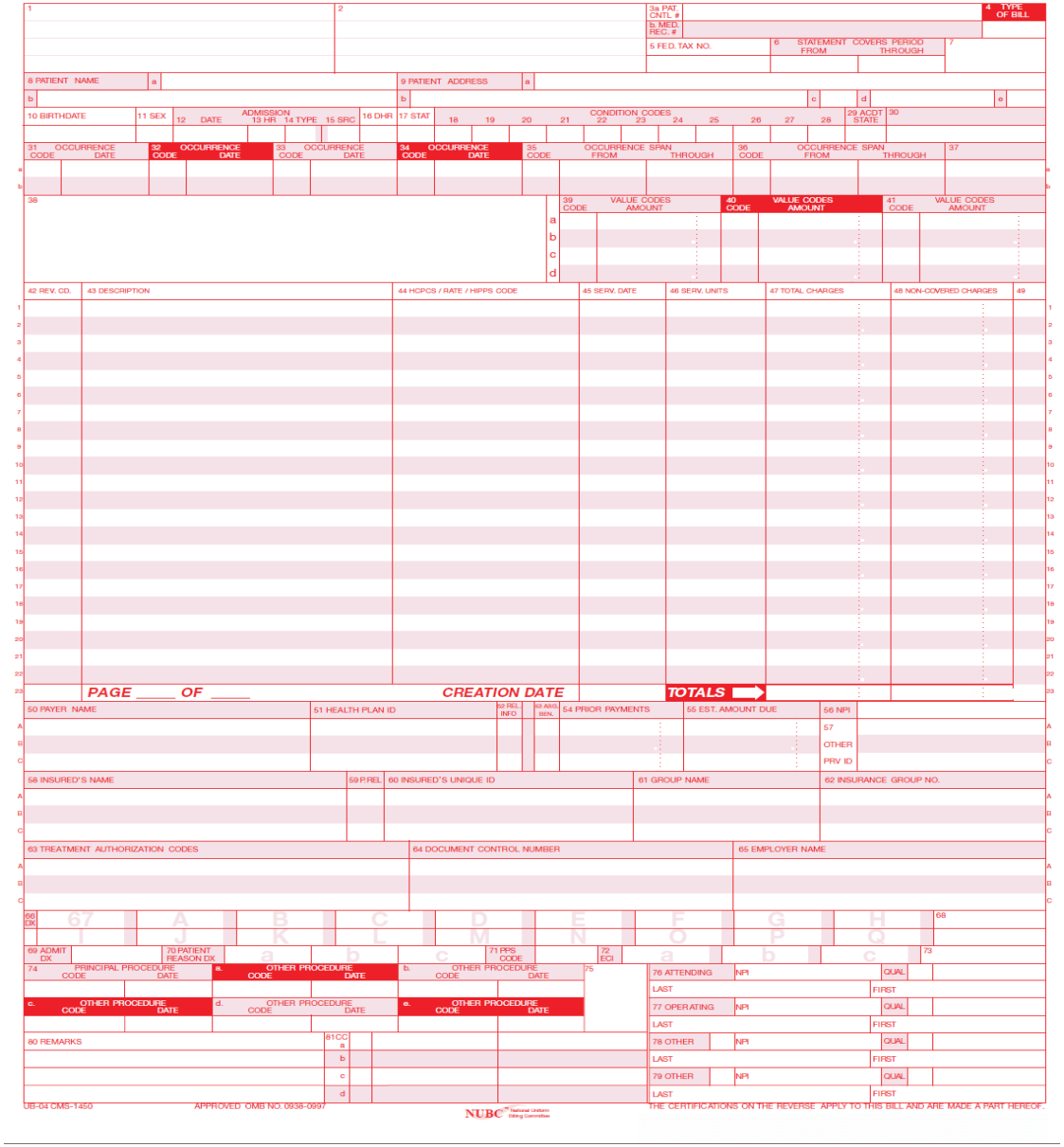
UB-04 Claim Form



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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 on myMDwise provider portal
- 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 made using the most current form version as designated by Center for Medicare and Medicaid Services.
- 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.

Note: EOP's are accepted via electronic submission with detail submitted at the line level.

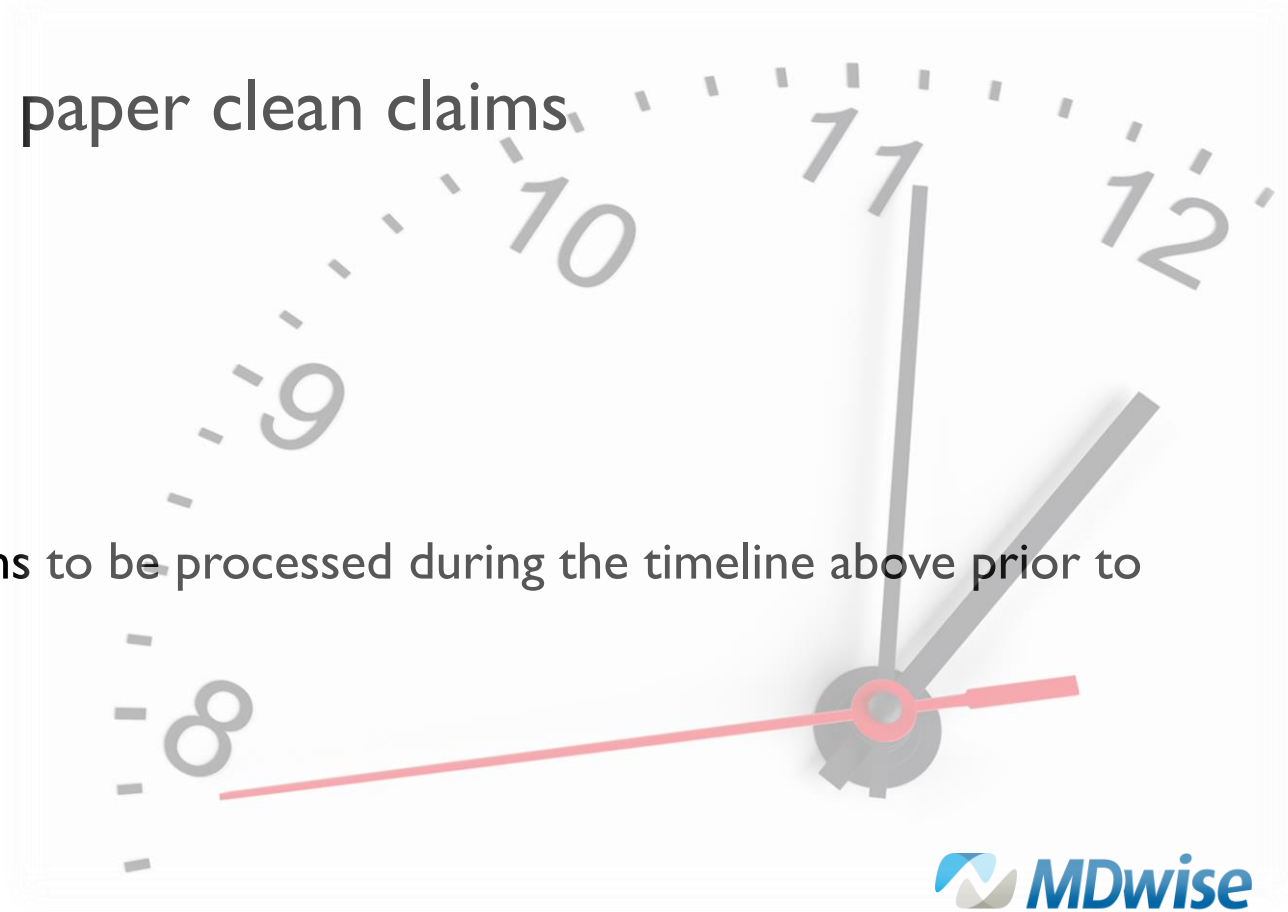
Claim Submission Timelines

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 from date of receipt:

- 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.

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

Provider Claim Adjustment Request Form

MDwise Provider Claim Adjustment Request Form Instructions

When To Use the Provider Claim Adjustment Form

A Claim Adjustment is a request for payment reconsideration for a paid or denied claim. Claim Adjustments must be submitted on a paper claim (not EDI) with supporting documentation related to the request. This includes:

- Check-related adjustments
- Non-check-related adjustments (i.e., underpayment, partial claim overpayment, and full claim overpayment)

If a claim is filed timely and is paid, including claims partially paid or paid at zero, and the provider disagrees with the reimbursement, the provider should submit a **Provider Claim Adjustment Request Form**. The claim adjustment or void/replacement must be filed within sixty (60) calendar days of notification of the claim's disposition, which MDwise considers the date of the most recent Explanation of Benefits (EOB).

- If the claim was paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider should submit the Claim Adjustment Form along with a copy of the corrected claim, and/or any supporting documentation.
- After the provider has made reasonable attempts to correct or adjust a claim, if the provider remains dissatisfied with the reimbursement, the provider should submit a claims dispute by submitting the **Claims Dispute Form** along with the documentation from the claim adjustment process, a copy of the claim, in addition to a summary of the dispute within ninety (90) calendar days from the date of the most recent EOB.
- Once a provider submits a Claims Dispute, they may not utilize a Claim Adjustment Form as an avenue to have the claim reviewed nor to extend the dispute timeframes.

Claim Adjustment Form Submissions

Claim Adjustment Form must be received within sixty (60) calendar days of the most recent MDwise Explanation of Benefits (EOB) along with a copy of the corrected claim, and/or any supporting documentation for the adjustment.

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

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

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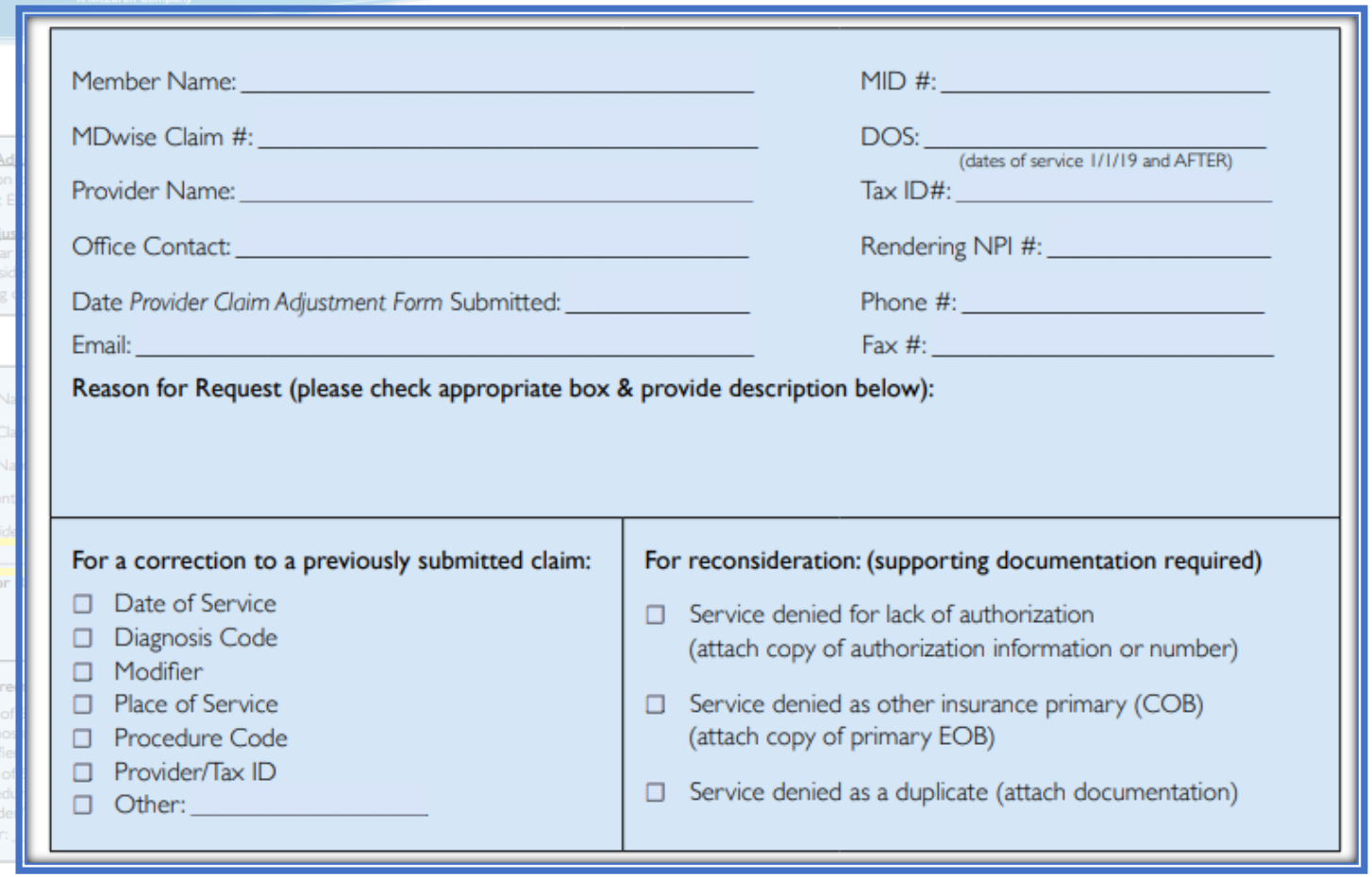
Provider Claim Adjustment Request Form con't



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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.

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

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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 any supporting documentation should be sent to one of the following:

MDwiseClaims@mclaren.org

OR

Fax request: 1-833-540-8649

Note:

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

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Provider Claim Adjustment Time Frame

- Form must be received **within 60 calendar days** of the most recent MDwise EOP
- Any inquiry or request made **after 60 calendar days** will not be considered
- Only one claim per Provider Claim Adjustment Form Request
- After a completed request form and supporting documents are received, an acknowledgment 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 is not satisfied with the outcome.

Claims Disputes

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When to Submit a Claim Dispute

Examples of denials that may constitute a dispute include:

- Timely filing
- Coding issues
- Prior authorization

The following DO NOT constitute a dispute:

- New claim
- Corrected claim
- Medical records
- Attachments (consent forms, invoices)
- Recoupment

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

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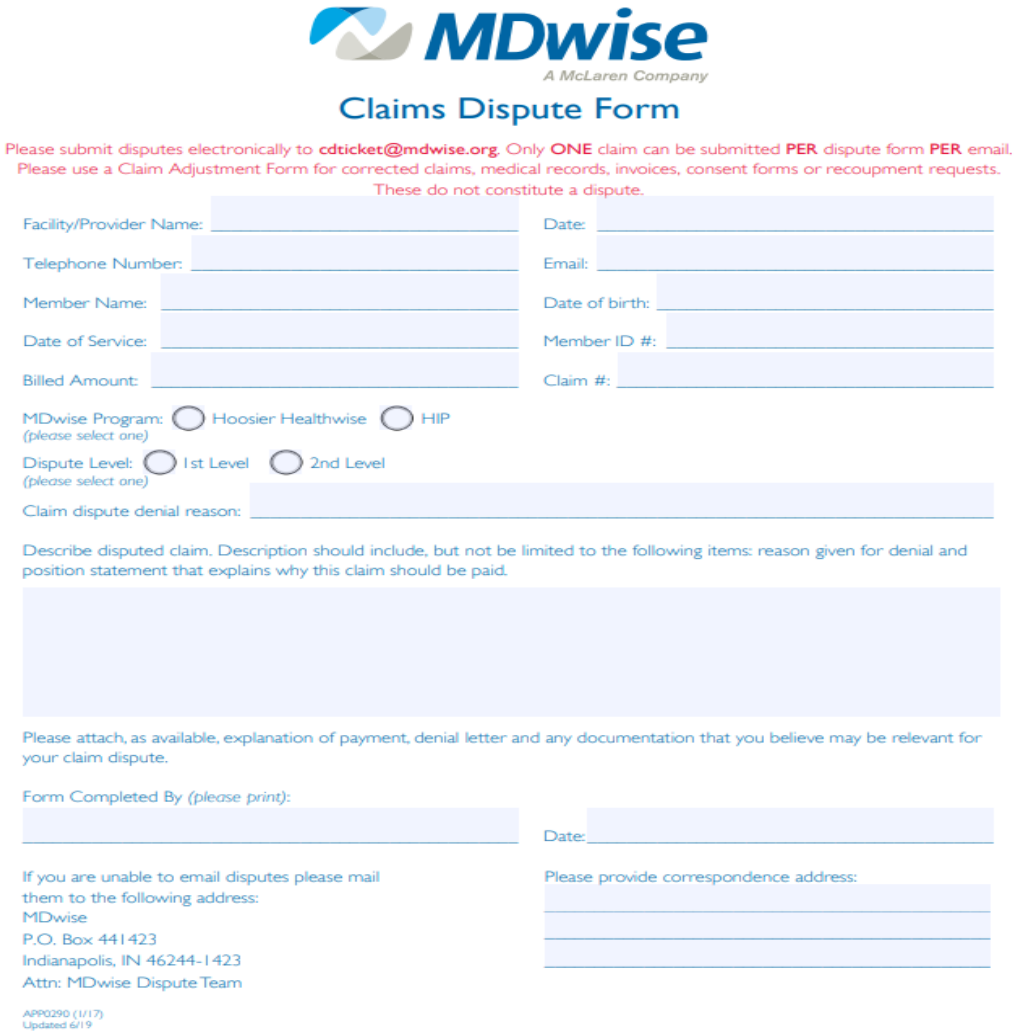
Submitting a Claim Dispute Request

- 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

Claim Dispute Form

Claim 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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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 90 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.

14 Day Re-admissions

- Inpatient readmission claims that are within 14 days of a previous discharge will be denied.

- Providers that receive a readmission denial and wish to file a dispute must complete a Readmission Dispute Form **within 90 days of a claim's determination.**

- A description of the disputed readmission claim should be included on the form, including but not limited to:
  - Medical reason for a Second claim being considered
  - Dates of service, claim numbers and medical records for **BOTH** admissions

Readmission Dispute Form

Readmission Dispute Form

Readmission Dispute Form

◯ First Level Dispute ◯ Second Level Dispute
(please select one)

Please submit this form and both required medical records to
Readmissions@mdwise.org

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)

Describe disputed claim. Description should include, but not be limited to the following items: Medical Reason 2nd claim should be considered, medical records for both admissions, claim date of service and claim number for both admissions.

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Where to Submit a Readmission Dispute Form

Submit completed Readmission Dispute Form via email to Readmissions@mdwise.org. A return email will be issued with a tracking ticket number.

If email is unavailable, mail to:

MDwise/McLaren Claims
P.O. Box 441423
Indianapolis, IN 46244-1423
Attn: Readmission Disputes

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CMS-1500 Claims Common Barriers

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Common Barriers

CMS – 1500

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

UB-04

- Revenue/CPT linkage
- Provider/Location not enrolled
- Appropriate taxonomy
- Present-on-Admission (POA) – Indicators missing or invalid for ICD-10 diagnosis codes

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Common Denials

- Past timely filing
  - Primary claims – 90 days
  - Secondary Claims – 90 days from primary EOP
  - Claim Adjustment Form (CAF) and/or Claim Dispute Form also have file limits
    - CAF – 60 days from date of EOP
    - Denial – 90 days from date of EOP
- Payment denied for absence of PA
  - Does service require PA?
  - Is provider contracted?
- Service is not reimbursable for this provider or location
  - Did you call PCSU to check this denial
  - Did you file an appeal
- Denied for noncovered
  - Did you file a CAF
  - Did the claim pay at a DRG rate or ASC rate

Denials vs. 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 cannot be reprocessed, corrected, 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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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).

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Resources

Claims Page

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

Claim Forms

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

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

Claim Inquiries

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

Resources

MDwise Manuals

https://www.mdwise.org/mdwise/mdwise-provider-manual

IHCP Provider Modules

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

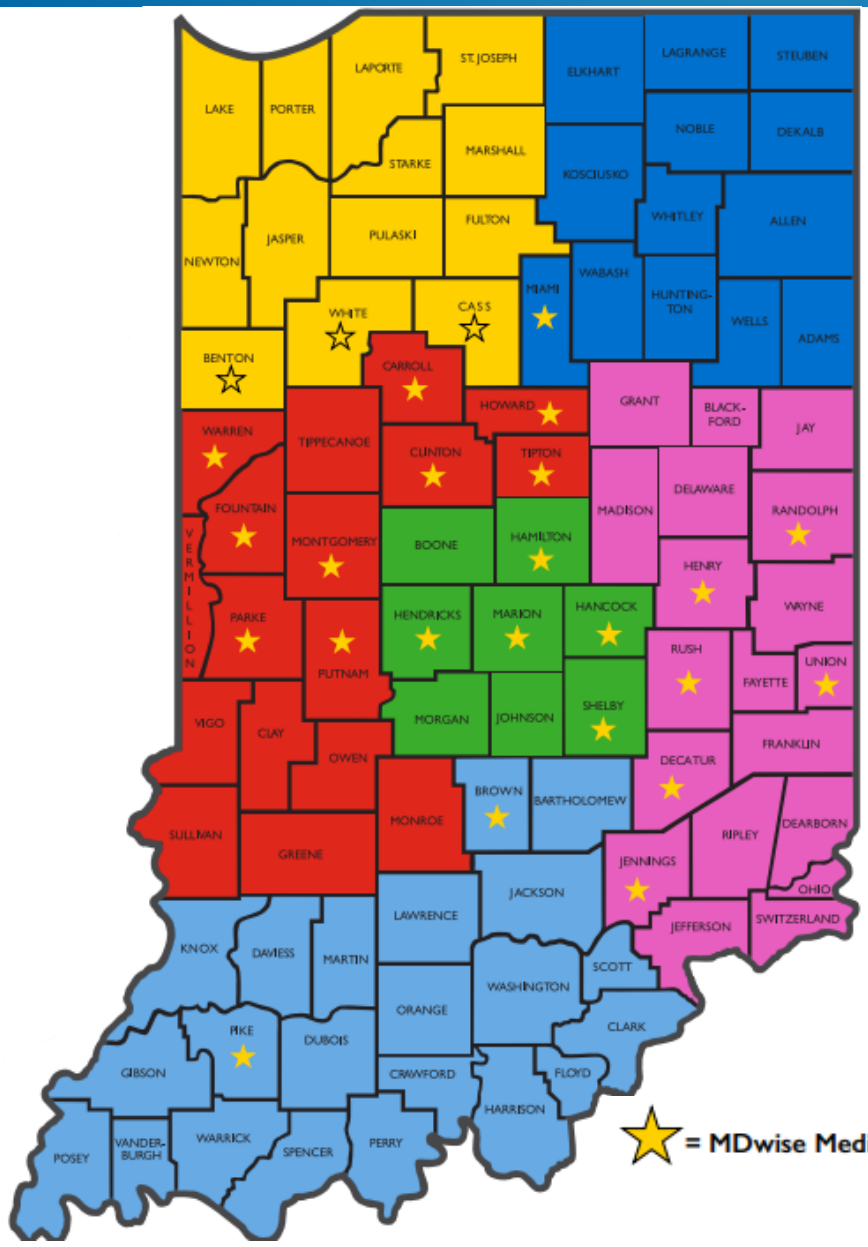
MDwise Claims: PCSU

1-833-654-9192

MDwise Member Customer Service

1-800-356-1204

MDwise Provider Relations Team



Region 1

Danyelle Pittman
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Region 2

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317-741-4352

Region 3

Lauryn Gooch
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Region 4

Joy Diarra
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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
Amanda Deaton adeaton@mdwise.org 317-914-5953	**Provider Groups** DME and HME Laboratory Services Dialysis Clinics American Health Network Out of State Providers

PROVIDER RELATIONS LEADERSHIP

Josh Burger

Director of Provider Relations
jburger@mdwise.org
317-460-4510

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Thank you!

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QUESTIONS?

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