IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201708 FEBRUARY 21, 2017

Confirm use of the correct user ID and password when logging on to the Provider Healthcare Portal

To log in to the Provider Healthcare Portal (Portal), Indiana Healthcare Coverage Programs (IHCP) providers must enter the user ID and password that was established during the Portal registration process. The IHCP has received inquiries from providers that are attempting to use their Web interChange user IDs and passwords in error. When an incorrect user ID and password are used, the system may present an incorrect set of security questions in an attempt to identify the user. If you receive incorrect security questions, please return to the login page and confirm that you have entered your Portal user ID and password. If you are still receive incorrect security questions, or if you are unable to access the Portal, contact the Service Desk at 1-800-457-4584.

Indiana*AIM* RAs available on Web interChange through March 15, 2017

On February 13, 2017, Web interChange was replaced by the new Indiana Health Coverage Programs (IHCP) Provider Healthcare Portal (Portal). Historical RAs for claims processed in Indiana*AIM* were not converted to the Portal. Using their established Web interChange user IDs and passwords, providers can continue to use the Check/RA Inquiry function in Web interChange to view historical Remittance Advices (RAs) for claims processed in the Indiana*AIM* system through March 15, 2017. Providers can access the Web interChange log-in either from the Web interChange page or from the left navigation panel under *General Provider Services* at indianamedicaid.com. Providers are encouraged to print RAs from Web interChange if they expect to need them for reference after March 15.

MORE IN THIS ISSUE

IHCP reminds home health providers to bill claims with appropriate revenue code/procedure code combinations

The Indiana Health Coverage Programs (IHCP) reminds providers to use appropriate revenue code/procedure code combinations when billing for home health services. The acceptable revenue codes for home health services are shown in Table 1. Failure to bill home health procedure codes with the correct revenue codes may result in claim denials.

Table 1 – Acceptable revenue codes for home health services

Revenue Code	Procedure Code	Revenue Code	Procedure Code
420	G0151	440	G0153
421	G0151	441	G0153
422	G0151	442	G0153
423	G0151	443	G0153
424	97001**, 97161, 97162, 97163	444	92521-92524
429	G0151	449	G0153
430	G0152	552	99600 TD
431	G0152	552	99600 TE
432	G0152	559	S9349*
433	G0152	559	99601, 99602
434	97003**, 97165, 97166, 97167	572	99600
439	G0152		

**S9349 is not a covered code effective March 16, 2016*
***97001 and 97003 were end-dated December 31, 2016*

Home health providers must use occurrence code 73 when billing for overhead payments

Indiana Health Coverage Programs (IHCP) *Provider Bulletins* BT201669 and BT201693 advised home health providers that they must bill occurrence code 73 for home health overhead payments for dates of service (DOS) on or after February 13, 2017. The previous occurrence code of 61 will not be valid for DOS after *Core*MMIS implementation. Claims submitted with occurrence code 61 for DOS on or after February 13, 2017, will deny with explanation of benefits (EOB) 551 – *An overhead amount did not appear on the claim*. Providers will need to edit the claim to correct the occurrence code and resubmit the claim for processing.

continued

NOTE: Home health claims processed from February 13, 2017, through February 16, 2017, that accurately included occurrence code 61 – based on a DOS on or before February 13, 2017 – may have, in error, included both EOB 0551 along with EOB 9009 – *Details includes overhead fee.* Presence of EOB 9009 ensures that the overhead was applied to the claim correctly, regardless of EOB 0551 also appearing. This inconsistency has been corrected, and providers should no longer see EOB 0551 unless there is no overhead billed or the wrong occurrence code is used.

Institutional claims: condition codes, occurrence codes and value codes "required" only when applicable

Institutional claims in the Provider Healthcare Portal (Portal) show an asterisk next to the Condition Codes, Occurrence Codes, and Value Codes fields. The asterisk denotes that the field is a required field. Providers should be aware that these fields are not required in every instance. An entry in these fields is required only ***if the fields are applicable to the specific claim or type of claim being submitted.***

As announced in *Core*MMIS *Bulletin* BT201667, *Core*MMIS uses Health Insurance Portability and Accountability Act (HIPAA)-compliant coding per national coding sources in its processing logic – including HIPAA-compliant condition codes, occurrence codes, and value codes. Providers should ensure they are using HIPAA-compliant values when billing the IHCP for claims processing in *Core*MMIS. **Note that an exception exists for occurrence codes billed on claims with dates of service before *Core*MMIS implementation. Providers must follow previous IHCP billing guidance regarding occurrence codes on claims for DOS on or before February 13, 2017.**

Information on when condition, occurrence, and value codes are required on claims for various provider types are found in the provider reference modules for inpatient, outpatient, long term care, home health, and hospice services. Changes in billing guidance for some provider types related to the use of these codes with *Core*MMIS implementation were announced in *Core*MMIS *Bulletin* BT201669.

Rendering providers must be linked to the specific service location for a claim to adjudicate correctly in *Core*MMIS

As announced in Indiana Health Coverage Programs (IHCP) *Provider Bulletin* BT201671, IHCP policy requires that rendering providers be linked to the specific locations where they render services for a group practice. Further, a rendering provider's services may not be billed for a service location to which he or she is not linked. Indiana*AIM* processing rules did not edit for a specific service location linkage when processing claims; rather, the system simply verified that the rendering provider was linked to any service location for a particular group provider. In *Core*MMIS, claims billed for services performed by a rendering provider not linked to the specific service location on the claim will deny. Group providers should review their provider profiles to ensure each group location has the correct rendering providers linked with accurate effective and end-dates.

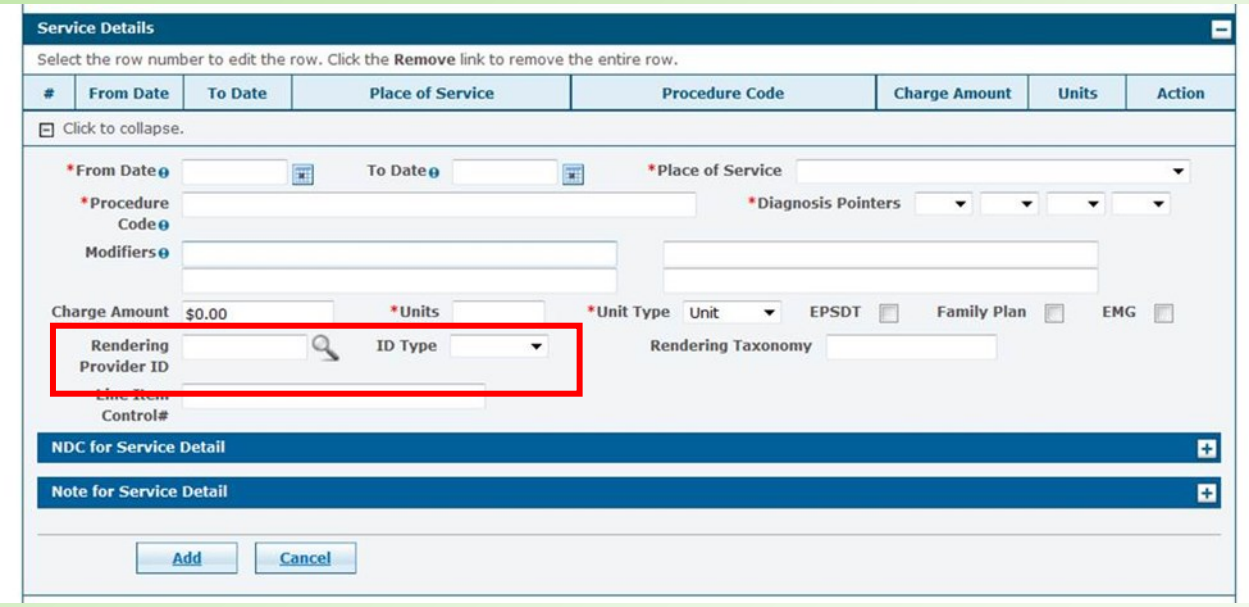
IHCP reminds providers to check the MCE portals for delivery system information

On a member eligibility response, the Provider Healthcare Portal (Portal) lists managed care entity (MCE) name and contact information, and the primary medical provider (PMP) name and contact information. The Portal does *not* list MCE delivery system information. This information can be found on the portal of the MCE with which the member is enrolled.

Waiver, home health, and transportation providers use Provider IDs for billing purposes

With the new Core Medicaid Management Information System (*Core*MMIS), atypical providers who do not have a National Provider Identifier (NPI) must use their Provider ID (formerly known as a Legacy Provider ID plus the service location code) when submitting claims on the Provider Healthcare Portal (Portal). The Provider ID number must be entered in the Rendering Provider ID field. In addition, **Provider ID** must be selected from the drop-down menu in the ID Type field. See Figure 1.

Figure 1: Screen shot of the "Rendering Provider ID" and "ID Type" fields in the Portal



Providers must submit TPL and Medicare crossover information at the detail level for some claim types

As announced in Indiana Health Coverage Programs (IHCP) *Provider Bulletin* BT201667, and further clarified in Banner Page BR201706, providers are required to submit third-party liability (TPL) information and Medicaid information at the detail level for certain claim types so that the claims will properly adjudicate in *Core*MMIS.

The claim types that require TPL at the detail level include:

- Medical
- Medical crossover (claim type B only)
- Dental
- Home health
- Outpatient

The claim types that require Medicare information at the detail level include:

- Medical crossover
- Outpatient crossover

All inpatient and long-term care claims will continue to process TPL and Medicare information at the header level.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com.

TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.