IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201720 MAY 16, 2017

Transportation code A0425 denying for NCCI MUE

The Indiana Health Coverage Programs (IHCP) *Core*MMIS claim-processing system complies with existing state policies, as well as state and national billing guidelines. However, there is currently a conflict between state and national billing guidelines regarding the National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs) for ground transportation mileage Healthcare Common Procedure Coding System (HCPCS) code A0425 – *Ground mileage, per statute mile*.

The IHCP is currently seeking approval from the Centers for Medicare & Medicaid Services (CMS) to deactivate the NCCI MUE edit for ground transportation mileage code **A0425** and modifiers U1, U2, U3, or U5. Until the IHCP receives approval, *Core*MMIS will deny fee-for-service (FFS) claim details billed with ground transportation mileage in excess of the 250-unit MUE with explanation of benefits (EOB) 4183 – *Units of service on the claim exceed the medically unlikely edit (MUE) allowed per date of service*.

To allow claims for ground transportation mileage to pay when the units billed exceed the NCCI MUE, providers are instructed to request an official administrative review of any claims for ground transportation mileage processed in *Core*MMIS that deny for EOB 4183. Requests for administrative review should be made using the *Indiana Health Coverage Programs Administrative Review Request* form, found on the *Forms* page at indianamedicaid.com. A copy of the Remittance Advice (RA) identifying the original claim denial, as well as a copy of this banner page, must be attached to the request form. The administrative review request must be submitted within 60 days of the date of the claim denial. The request, along with the supporting documentation, may be submitted via the Secure Correspondence feature on the Portal or via mail to: **Written Correspondence, P.O. Box 7263, Indianapolis, IN 46207-7263**.

Providers that do not submit an administrative review request will have their claims mass reprocessed if approval is received from the CMS. The IHCP will announce the CMS decision when it is received.

POA indicator issues corrected in *Core*MMIS and the Portal

The Indiana Health Coverage Programs (IHCP) identified claim processing and Provider Healthcare Portal (Portal) issues associated with the Present on Admission (POA) indicator on institutional claims. The issues, affecting claims processed on or after the implementation of *Core*MMIS, have been corrected:

- Long-term care crossover claims were incorrectly denying for explanation of benefits (EOB) 4276 – *A present on admission (POA) code must be entered. A POA of 1 or blank is not acceptable,* when the POA field on the claim was left blank.
- The Portal did not include an option for the POA field to be left blank.

continued

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Claims processed in *Core*MMIS that inappropriately denied for EOB 4276 will be mass reprocessed. Providers will begin seeing reprocessed claims on Remittance Advices (RAs) the week of June 21, 2017, identifiable by internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claim).

The Portal now allows providers to leave the POA field blank, as appropriate. Inpatient and inpatient crossover claims require a POA indicator for all primary and secondary diagnosis codes, except for diagnosis codes that have been designated exempt from POA reporting. If the POA field is left blank for a nonexempt diagnosis code on an inpatient or inpatient crossover claim, the claim will appropriately deny for EOB 4276. Providers submitting claims where the POA indicator is required should use the indicators shown in Table 1 in the POA field.

Table 1 – POA indicators for inpatient and inpatient crossover claims

***UB-04* claim form or 837I transmission**	**Portal inpatient claim**	**Definition**
Y	Yes	Present at the time of inpatient admission
N	No	Not present at the time of inpatient admission
U	Unknown	The documentation is insufficient to determine if the condition was present at the time of inpatient admission
W	Not Applicable	The provider is unable to clinically determine whether the condition was present at the time of inpatient admission
[Blank]	[Blank]	Diagnosis is exempt from POA reporting

IHCP identifies top 20 EOB denial codes

The Indiana Health Coverage Programs (IHCP) has identified the top 20 explanation of benefits (EOB) codes issued for denials of claims processed in *Core*MMIS for all provider types. Table 2 includes the EOB code, the EOB description, and additional information providers should consider when determining the reason for denial and possible corrections for adjustment or resubmission.

Table 2 – Top 20 reasons for claim denials in CoreMMIS

EOB code	**EOB description**	**Additional things to consider**
198	*The referring NPI submitted is not in a valid format.*	The “referring” provider must be enrolled with the IHCP on the date of service (DOS) billed, including providers enrolled only as ordering, prescribing, or referring (OPR) providers. See the *Claim Submission and Processing* provider reference module for complete billing instructions for each claim type.

continued

Table 2 – Top 20 reasons for claim denials in CoreMMIS (continued)

EOB code	EOB description	Additional things to consider
224	*The diagnosis treatment indicator is not in the correct format-the number(s) must reference at least one of the corresponding applicable diagnosis codes entered.*	Claims submitted on the *CMS-1500* professional claim or 837P electronic transaction, including medical crossover claims, must have a valid diagnosis pointer at the detail level. Valid values are the digits 1 through 12; values must be entered with digits only and no spaces.
268	*The billed amount is missing.*	Claim details billed with an amount of $0 will deny. Appropriately, this denial EOB will post as expected for claim details for procedure codes of vaccines that are included in the Vaccines for Children (VFC) program.
520	*Invalid revenue code and procedure code combination.*	*Core*MMIS requires a procedure code be included on any outpatient or outpatient crossover claim for any service billed with a revenue code, if the revenue code requires a procedure code per national coding guidelines or IHCP policy. See *BT201669* for IHCP policy exceptions to this policy. It is important for providers to stay abreast of updates to the uniform billing (UB) editor and any IHCP publications regarding policy exceptions to this policy.
558	*Coinsurance and deductible amount is missing indicating this is not a crossover claim.*	Claims submitted with a Medicare paid amount must include coinsurance and deductible amounts.
593	*At least one detail submitted contains Medicare COB data resulting in a review of all detail COB data.*	Crossover (Medicare/Medicaid) claims with $0 in all fields – the Medicare Paid, Medicare Coinsurance, and Medicare Deductible fields – are interpreted by *Core*MMIS to indicate that the claim detail was denied by Medicare.
1010	*Rendering provider is not an eligible member of billing group or the group provider number is reported as the rendering provider.*	IHCP policy requires rendering providers to be linked to the specific locations where they render services for a group practice. For example, if a group has three locations (A, B, and C) and Dr. Smith practices at locations A and B, then Dr. Smith must be linked to the A and B locations. A claim detail submitted by location C with Dr. Smith billed as the rendering provider will deny. "Group" providers must enter the National Provider Identifier (NPI) for the rendering provider in the "Rendering" field; the Group's Provider ID cannot be entered in this field.
1027	*Referring physician number is not on file.*	Billing providers with a scope of practice that require an order, a referral, or a prescription for services to be rendered must include the NPI of the ordering, referring, or prescribing practitioner on the claim. Further, the NPI must be associated with an IHCP-enrolled provider. Provider types to which this requirement applies include, but are not necessarily limited to, therapist, durable medical equipment (DME), laboratory, and radiology.
1109	*The billing NPI is reported to multiple service locations.*	If the billing provider's NPI crosswalks to multiple service locations and a unique match cannot be found, the claim will deny. Providers should ensure that the appropriate taxonomy code and ZIP Code plus 4 are submitted with the billing provider NPI.

continued

Table 2 – Top 20 reasons for claim denials in CoreMMIS (continued)

EOB code	EOB description	Additional things to consider
1121	*The rendering provider NPI submitted is reported to multiple LPI.*	If the rendering provider NPI submitted at the claim detail is linked to more than one IHCP Provider ID, the detail will deny. Providers should ensure that the appropriate taxonomy code is submitted in the rendering field, along with the rendering provider NPI.
2017	*The member is enrolled in the Risk Based Managed Care portion of Hoosier Healthwise Program or has been identified as a member of the Hoosier Care Connect Program. The member must seek care from the appropriate managed care entity.*	Claims for services delivered through the managed care delivery system must be billed to the managed care entity (MCE) and will deny when processed in *Core*MMIS. The only services carved out of MCE responsibility for which claims should be submitted for processing in *Core*MMIS are: • Dental (for dates of service before January 1, 2017) • Medical Review Team (MRT) • Preadmission Screening and Resident Review (PASRR) • Medicaid Rehabilitation Option (MRO) • Child Mental Health Wraparound (CMHW) • Adult Mental Health Habilitation (AMHH) • Behavioral and Primary Healthcare Coordination (BPHC) • Psychiatric residential treatment facility (PRTF) Services performed by school corporations are also carved out of the MCE responsibility and paid via fee-for-service.
2033	*Invalid claim type for the program billed.*	The claim type submitted must be appropriate for the services covered under the benefit plan for which the member is eligible on the DOS. For example, if a member is covered by the Family Planning benefit plan on a particular DOS, inpatient services submitted on the *UB-04* institutional claim or 837I electronic transaction will deny.
2505	*This member is covered by private insurance which must be billed prior to Medicaid.*	Medicaid is the payer of last resort; a member's private insurance must be billed before billing the IHCP. If the provider discovers the IHCP member record regarding private insurance is out of date, the provider can request an update to the member's file. Complete billing guidance for members with private insurance is in the *Third-Party Liability* provider reference module.
4013	*This procedure is not covered for the date of service.*	The procedure billed is either a noncovered service or the provider's enrollment does not allow billing for that service.
4021	*Procedure code is not covered for the date of service for the program billed.*	The service billed is not covered under a member's benefit plans for the DOS billed.
4033	*The modifier used is not compatible with the procedure code billed.*	*Core*MMIS claim processing follows *Health Insurance Portability and Accountability Act* (HIPAA)-compliant coding standards and/or published IHCP policies with respect to the modifier and procedure code combinations.
4107	*Revenue code or type of claim is not appropriate/not covered for the type of service or type of provider.*	IHCP policy dictates the revenue codes that may be billed by certain provider types and on certain claim types. For information about billing revenue codes, see the *Claim Submission and Processing* or service-specific provider reference module found on the *Provider Reference Materials* page at indianamedicaid.com.

continued

Table 2 – Top 20 reasons for claim denials in CoreMMIS (continued)

EOB code	EOB description	Additional things to consider
4218	*Service billed is not allowed on this claim type.*	*Core*MMIS enforces strict claim type-to-provider type billing policy. The *Claim Submission and Processing* provider reference module clearly defines the provider types that can submit each type of claim or electronic transaction. The most common reasons for denials surround the following billing errors: • Rehabilitation hospital facility billing on the *CMS-1500* professional claim or 837P electronic transaction – This provider type should be billing on the *UB-04* institutional claim or 837I electronic transaction. • American Dental Association (ADA) codes billed on the *CMS-1500* professional claim or 837P electronic transaction – These codes should be billed on the *ADA 2006* dental claim or 837D electronic transaction. • Physical therapy providers billing on the *UB-04* institutional claim or 837I electronic transaction – This provider type should be billing on the *CMS-1500* professional claim or 837P electronic transaction.
5001	*This is a duplicate of another claim.*	If the billing provider, Member ID, DOS, and service procedure codes are an exact match to a claim that has already paid the claim is considered a duplicate claim.
5008	*Original ICN not present on 837 or not found in history.*	An adjustment to a paid claim submitted via the 837 electronic transaction must include the internal control number (ICN)/Claim ID of the original claim and the ICN/Claim ID must accurately match the original claim in *Core*MMIS.

Save the date for the 2017 second-quarter IHCP provider workshops

The Indiana Health Coverage Programs (IHCP) will offer provider workshops around the state in June and July. The locations and dates are shown in Table 3. Workshops are scheduled from 9 a.m. to 3:30 p.m. local time on each date. Sessions will include updates and roundtable discussions with managed care entities (MCEs). Session topics include:

- Managed Health Services (MHS) updates and reminders
- Anthem's summer 2017 updates for Hoosier Healthwise, Healthy Indiana Plan (HIP), and Hoosier Care Connect
- MDwise presentation on its new payer portal and discussion of claim submission, disputes, coordination of benefits, and more
- CareSource network credentialing and contracting, and provider portal functionality
- A collaborative presentation from the MCEs for behavioral health providers

- DXC Technology updates, including detailed Provider Healthcare Portal and TPL instructions

Mark your calendars and watch upcoming publications for more information about registering for the workshop nearest you.

continued

Table 3 – Dates and locations for summer IHCP provider workshops

Date	Location
June 21, 2017	St. Joseph Regional Hospital Lower Level Conference Room 5215 Holy Cross Parkway Mishawaka, Indiana
June 22, 2017	St. Catherine Hospital Birthing Center Training Room 4321 Fir Street East Chicago, Indiana
June 27, 2017	Dearborn County Hospital Dearborn/Ohio Room 600 Wilson Creek Road Lawrenceburg, Indiana
June 29, 2017	Lutheran Hospital Kachmann Auditorium 7950 West Jefferson Boulevard Fort Wayne, Indiana
July 12, 2017	Reid Hospital Lingle Auditorium 1100 Reid Parkway Richmond, Indiana
July 13, 2017	IU Health Bloomington Hospital Wagmiller Auditorium 601 West 2nd Street Bloomington, Indiana
July 17, 2017	Community North Hospital Multiservice Room, Third Floor 7250 Clearvista Parkway Indianapolis, Indiana
July 18, 2017	Baptist Health Paris Health Ed Center 1850 State Street New Albany, Indiana
July 25, 2017	IU Health Methodist Hospital Petticrew Auditorium 1701 North Senate Boulevard Indianapolis, Indiana (Parking is $5)
July 26, 2017	Deaconess Hospital Bernard Schnacke Auditorium 600 Mary Street Evansville, Indiana
July 31, 2017	Wabash Valley Alliance Medical Center 415 North 26th Street, Fourth Floor Lafayette, Indiana

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