IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201748 NOVEMBER 28, 2017

IHCP reminds providers paper claims must be submitted on NUCC red claim forms effective January 1, 2018

As announced in Indiana Health Coverage Programs (IHCP) *Banner Page* BR201721, effective January 1, 2018, paper claims submitted to the IHCP must be on the official red claim forms developed by the National Uniform Claim Committee (NUCC). The IHCP will no longer accept black-and-white copies. This change applies to the *CMS-1500* claim form 1500 (02-12) and the *UB-04 CMS-1450*. This change does not apply to dental claims submitted on the approved American Dental Association (ADA) claim form.

The IHCP retains electronic images of all paper claims submitted, and the red claim forms allow for optical character recognition (OCR), which enables the claim-processing system to read the characters submitted on the claim forms for quicker processing with fewer keying errors. Further, for proper imaging and processing, paper claims should not contain highlights or color marks, and liquid paper correction fluid (Wite-Out®) should not be used. Paper claims should not have any writing outside the approved fields.

Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not submitted on the correct form will be returned to providers without being processed. If a claim is returned, the provider must refile the claim on the correct red claim form. Timely filing requirements will apply to resubmitted claims.

Providers may purchase these NUCC red claim forms from a variety of vendors, the U.S. Government Publishing Office, or the U.S. Government Bookstore.

IHCP to revise rates for select durable medical equipment and medical supplies based on 2018 Medicare rates

Pursuant to *1903 (i) (27)* of the *Social Security Act*, Medicaid reimbursement for durable medical equipment and medical supplies cannot exceed the Medicare rate of reimbursement. Therefore, in accordance with the durable medical equipment and medical supplies reimbursement methodology set out in *405 IAC 5-19-1* through *8*, the Indiana Health Coverage Programs (IHCP) will adopt the 2018 Medicare rates for any durable medical equipment or medical supplies procedure code for which the IHCP's current reimbursement rate exceeds the 2018 Medicare rate. These rate changes will be effective for dates of service on or after January 1, 2018, and will be reflected on the IHCP *Professional Fee Schedule* and *Outpatient Fee Schedule* at indianamedicaid.com.

The *2018 Durable Medical Equipment and Medical Supplies Fee Schedule* will be available on the Centers for Medicare & Medicaid Services (CMS) website at cms.gov.

MORE IN THIS ISSUE

Providers may resubmit claims billed with certain podiatry services diagnosis codes that may have denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affected fee-for-service (FFS) claims for podiatry services billed with the ICD-10 diagnosis codes in Table 1, for dates of service (DOS) on or after February 13, 2017, when *Core*MMIS was implemented. Claims billed with these diagnosis codes may have inappropriately denied for explanation of benefits (E0B) 3419 – *Routine foot care treatments are limited to specific diagnosis codes*.

Table 1 – Diagnosis codes that may have caused claims to deny incorrectly, for DOS on or after February, 13, 2017

Diagnosis Code	Description
G57.53	Tarsal tunnel syndrome, bilateral lower limbs
M21.611	Bunion of right foot
M21.612	Bunion of left foot
M21.619	Bunion of unspecified foot
M21.621	Bunionette of right foot
M21.622	Bunionette of left foot
M21.629	Bunionette of unspecified foot

The claim-processing system has been corrected. Effective immediately, providers may resubmit claims with the affected diagnosis codes that may have denied incorrectly for EOB 3419 for reimbursement consideration. Claims resubmitted beyond the one-year filing limit must include a copy of this banner page as an attachment, and must be resubmitted within one year of the publication date.

Providers may resubmit claims billed with certain surgical services diagnosis codes that may have denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affected fee-for-service (FFS) claims for surgical services billed with the ICD-10 diagnosis codes in Table 2, for dates of service (DOS) on or after February 13, 2017, when *Core*MMIS was implemented. Claims billed with these diagnosis codes may have inappropriately denied for explanation of benefits (E0B) 6691 – *Procedure code must be billed with ICD diagnosis code in order to reimburse for percutaneous angioplasty of the carotid artery.*

Table 2 – Diagnosis codes that may have caused claims to deny incorrectly, for DOS on or after February, 13, 2017

Diagnosis Code	Description
I63.033	Cerebral Infarction due to thrombosis of bilateral carotid arteries
I63.133	Cerebral infarction due to embolism of bilateral carotid arteries
I63.233	Cerebral infarction due to unspecified occlusion of stenosis of bilateral carotid arteries

continued

The claim-processing system has been corrected. Effective immediately, providers may resubmit claims with the affected diagnosis codes that may have denied incorrectly for EOB 6691 for reimbursement consideration. Claims resubmitted beyond the one-year filing limit must include a copy of this banner page as an attachment, and must be resubmitted within one year of the publication date.

Prior authorization is now required for HCPCS code C9484

Effective December 28, 2017, the Indiana Health Coverage Programs (IHCP) will require prior authorization (PA) when providers bill for Healthcare Common Procedure Coding System (HCPCS) C9484 – *Eteplirsen, Injection, 10mg*. This change applies to dates of service (DOS) on or after December 28, 2017.

Exondys 51 (eteplirsen) is an antisense oligonucleotide indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping.

PA for the prescribed drug requires the following criteria be met:

- Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 51 skipping
- Dose is 30 mg/kg once weekly (patient weight must be provided to confirm dose)
- Prescriber must provide documentation of current clinical status to compare upon re-evaluations of therapy (for example, Brooke Score, 6-minute walk test, and so on)

This PA requirement change applies to services delivered under the fee-for-service (FFS) delivery system. Questions regarding FFS PA should be directed to Cooperative Managed Care Services at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish PA criteria within the managed care delivery system. Questions regarding managed care PA should be directed to the MCE under which the member is enrolled.

PA information will be reflected in the next regular updates to the IHCP *Professional Fee Schedule,* and the *Outpatient Fee Schedule* at indianamedicaid.com.

IHCP delays date for implementing enhanced provider profile information on the Portal

The Indiana Health Coverage Programs (IHCP) announced in *Banner Page* *BR201741* that, effective November 30, 2017, providers would be able to view additional provider profile information in the IHCP Provider Healthcare Portal. The date for implementing this enhancement has been delayed. The new implementation date will be published once it is established.

Providers can refer to the original article in *BR201740* for details about the new profile information that will be available. Watch future IHCP provider publications for an implementation update.

QUESTIONS?

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

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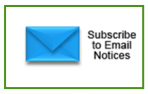

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