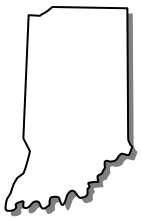
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Providers

Subject: HIPAA Modifications

Overview

The purpose of this bulletin is to provide information about system modifications that are effective June 6, 2005. These modifications affect Indiana*AIM* and Web interChange. This information is also available on the www.indianamedicaid.com Web site on the What's New for Providers Web page. In addition, providers can refer to the IHCP 837 Institutional, Professional, and Dental Transactions companion guides at http://www.indianamedicaid.com/ihcp/TradingPartner/tp_companion_guides.asp. The companion guides reflect information about the modifications provided in this bulletin.

Coordination of Benefits Revisions

Effective June 6, 2005, coordination of benefits (COB) information for crossover and third party liability (TPL) claims is available in Web interChange. The enhancements allow providers to submit HIPAA-related information using the 837 transactions. Detailed information about COB claim entry is available at www.indianamedicaid.com, under **Coordination of Benefits**. In addition, providers can access the help menu in Web interChange.

If a claim does not cross over automatically from Medicare, providers should pay special attention to changes in the way Medicare Part A and Part B crossover claims are submitted. For the Indiana Health Coverage Programs (IHCP) to accept these claims as crossovers, the provider must correctly use the payer primary identification number and the claim filing indicator code of MA or MB.

Until June 22, 2005, the IHCP will accept crossover amounts at the claim or service line level for Medicare Part A and Part B crossover claims. After June 22, 2005, the IHCP will only accept crossover amounts at the service line level for Medicare Part B and C crossover claims. Only crossover amounts at the claim level will be used for Medicare Part A crossover claims.

The IHCP only accepts all other payer payment (third party liability) claim information at the claim level. The provider should use the primary identification number and the claim filing indicator (other than MA or MB) to ensure the claim is accepted with the payer information.

Providers may enter other subscriber, payer, patient, and other payer payment adjustment information. The IHCP encourages providers to complete these sections to improve the information the IHCP currently maintains about its members.

Dental Rendering Provider Information

Dental Rendering Provider Information at the Service Line Level

For all dental claims, dental providers are required to submit rendering provider information at the service line level when the billing provider is a group. Rendering providers are required to be associated with the billing provider's group. The requirement to record the individual dentist performing the service is an added HIPAA requirement. The IHCP captures the rendering provider information at the service line level.

The provider must include rendering provider number in the administrative column on the *ADA 2000 Dental Claim* form. Providers may also submit dental rendering provider information via Web interChange.

Providers should contact the Provider Enrollment Helpline at 1-877-707-5750 for answers to questions about dental group or rendering provider numbers.

Dental rendering provider information is contained in the 835 transaction.

Remittance Advice

Because compliance changes required by HIPAA legislation have resulted in revisions to the 835 Transaction, the IHCP is also revising the paper remittance advices (RAs) effective June 6, 2005. RAs provide information about adjudicated claims that are paid, denied, or adjusted. Paper RAs include information about in-process claim data and financial transactions. Additionally, claim correction forms (CCFs) are mailed with the paper RA statement and the IHCP banner page. Detailed information about RAs, which includes field definitions and report layouts, can be found on the www.indianamedicaid Web site. Providers should ensure that staff members who are responsible for filing and posting claims are aware of the changes to the paper RAs.

Voids and Replacements

Currently, providers can submit requests to void a claim for full recoupment or modify the data on a claim (replacement) through submission to EDS by mail on paper adjustment forms only. This process applies to check and non-check-related adjustment requests and only applies to post-financial claims.

With the implementation of the enhancements to the 837 transactions, providers are able to submit an electronic void or replacement for a previously submitted claim. A void and replacement can be completed on the same day or in the same week as a claim submission, and after the payment is finalized. This modification only applies to non-check-related replacements; however, it applies to both pre-financial and post-financial claims. New region codes are assigned to post-financial claims for electronic voids or replacements.

A replacement request that includes a check still requires submission through the current paper adjustment request process.

Providers can submit an electronic void and replacement through Electronic Data Interchange (EDI) or Web interChange. Effective June 6, 2005, Web interChange will be modified to include the functions for voids and replacements.

The claim inquiry transaction remains the same; however, function buttons have been added for void and replacement.

Provider-initiated electronic replacements (formerly called adjustment requests) are submitted with claim frequency code **7** and become a new claim (including attachments and claim notes).

Provider-initiated electronic voids (formerly called claim reversals) are submitted with claim frequency code **8**.

A void is the cancellation of an entire claim. Providers should note the following related to voids:

- A void cancels a claim.
- A denied claim can not be voided.
- A denied claim can only be replaced via the electronic method using EDI or Web interChange.

The Web interChange Help Page includes more information about submitting electronic voids and replacements.

> *Note: The IHCP 837 companion guides have been updated to reflect this information about voids and replacements. The companion guides are available at http://www.indianamedicaid.com/ihcp/TradingPartner/tp_companion_guides.asp.*

Claim Notes

Effective June 6, 2005, the system will be updated so that it accepts claim note information in electronic 837 claim transactions and retrieves the information for review during processing. This system enhancement reduces the number of attachments that must be sent with claims. Also, in some instances, use of the claim note may assist with the adjudication of claims.

For example, when post-operative care is performed within one day of surgery; providers can submit supporting information in the claim note segment rather than sending an attachment.

When a provider submits claims electronically, via an 837 transaction or Web interChange claim submission the following is true for claim notes:

- At the header level, the IHCP accepts 20 claim notes for the 837D transaction, 10 claim notes for the 837I transaction, and one claim note for the 837P transaction.
- At the detail level, the IHCP allows 10 claim notes on the 837D transaction and one claim note on the 837P transaction.
- The IHCP does not support detail level claim notes on the 837I transaction.

Claims Notes Accepted as Documentation

Third Party Payer Fails To Respond (90 Day Rule)

When a third party insurance carrier fails to respond within 90 days of the provider's billing date, the provider can submit the claim to the IHCP for payment consideration. However, the following must be documented **in bold** in the claim note segment of the 837P transaction to substantiate attempts to bill the third party:

- Date of the filing attempt
- The phrase “no response after 90 days”
- The member’s RID number

- The provider's IHCP provider number

Abortion Diagnosis/Procedure Indicated

In the claim note, the IHCP accepts indication of medical documentation that supports the need to save the mother's life or a police report that indicates rape or incest.

Submission of Miscellaneous Drug Injection Codes

The provider should indicate the National Drug Code (NDC) code for the drug dispensed in the claim notes segment.

Identification of Supernumerary Tooth Extractions

If using the claim note segment, the provider should identify the affected tooth by indicating one of the following:

- Adult – Designate the tooth ID by the appropriate tooth number followed by an **A**
- Child – Designate the tooth ID by the appropriate tooth letter followed by a **1**

Consultations Billed 15 Days Before or After Another Consultation

In the claim note, the provider can indicate the medical reason for a second opinion during the 15 days before or after the billed consultation.

Joint Injections – Four per Month

In the claim note, the provider can document that the injections are performed on different joints and indicate the sites of the injections.

Surgery Payable at Reduced Amount When Related Post-Operative Care Paid, Post-Operative Care Within 00-90 Days of Surgery, Pre-Operative Care on Day of Surgery, and Surgery Payable at Reduced Amount When Pre-Operative Care Paid Same Date of Service

In the claim note, the IHCP accepts the following:

- Information that documents the medical reason and unusual circumstances for the separate evaluation and management (E/M) visit.
- Information that supports that the medical visit occurred due to a complication, such as, cardiovascular complications, comatose conditions, elevated temperature for two or more consecutive days, medical complications due to anesthesia other than nausea and vomiting, post operative wound infection requiring specialized treatment, or renal failure.

Pacemaker Analysis – Two Within Six Months

The provider should use the claim note to document the medical reason for the second analysis in the six-month time frame, such as a dysfunctional pacemaker.

Assistant Surgeon Not Payable When Co-surgeon Paid

In the claim note, the IHCP accepts information that documents the medical reason for the assistant surgeon, such as the situational problem requiring assistance.

Excessive Nursing Home Visits or More Than One per 27 Days

In the claim note, the IHCP accepts documentation supporting the treatment of emergent, urgent, or acute conditions or symptoms with the new diagnosis code.

Early and Periodic Screening Diagnosis and Treatment Referral Indicator

Effective June 6, 2005, the system will capture more information related to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services through the 837 transaction. The 837 claim submission procedures can be found in the 837 Companion Guides located on the IHCP Web site. This rule only applies to professional and dental claim types.

In addition, providers who bill for EPSDT services using the paper CMS-1500 claim forms should use a value of **Y** in field 24J in the COB field at the service line.

ICD-9 Diagnosis Codes

Institutional

Formerly, for inpatient claims submitted using the 837I electronic transaction, the system required an admit diagnosis code, a primary diagnosis code, an E code diagnosis code, and a second through ninth diagnosis code. Beginning June 6, 2005, the system will accept the admit, primary, E code, and 24 secondary diagnosis codes. The same edits and audits that are in place for the diagnosis codes two through nine will be in place for the diagnosis codes 10 through 24.

> *Note: In addition, the IHCP continues to use the All-Patient (AP) DRG Grouper, version 18 and acceptance of the additional diagnoses does not change ICD-9 coding policies.*

Procedure Codes

Formerly, the provider entered the principal procedure code and date on an institutional claim submitted on the paper UB-92 claim form or via the 837I electronic transaction. Effective June 6, 2005, the provider may enter the principal procedure code and 24 secondary procedure codes and dates when submitting claims using the 837I electronic transaction or Web interChange.

Professional

Formerly, providers could submit as many as four diagnosis codes on the claim. As of June 6, 2005, the system will accept as many as eight diagnosis codes on the claim. The paper CMS-1500 claim form continues to accept four diagnosis codes.

The system edits all diagnosis codes for validity. The system will edit the four additional diagnosis codes permitted on the 837P transaction.

The system allows four diagnosis code pointers on the service line to represent any of the eight claim diagnosis codes. Each service line may point to as many as four of the eight listed diagnosis codes. This information is also available on the Web interChange Claim Submission Web page.

Modifier Remediation

Effective June 6, 2005, the IHCP is capturing and editing the fourth modifier on professional claims submitted for processing on the CMS-1500 paper claim form and via the 837P electronic transaction.

The system captures and edits as many as four modifiers on institutional claims submitted for processing on the UB-92 paper claim form and via the 837I electronic transaction. However, the modifiers **are not used** for processing on inpatient, LTC, and outpatient claims. The modifiers **are used** for processing on home health claims. Providers should refer to the most recent version of the Current Procedural Terminology (CPT®) for a list of modifiers approved for Ambulatory Surgery Center (ASC) hospital outpatient use.

Number of Details

Prior to June 6, 2005, the system supported the following number of details per claim:

- 837I – 47 details
- 837P – 33 details
- 837D – 28 details

Claims that exceeded these limits were rejected with an error code *299 - more than the maximum detail records were received*, on the Biller Summary Report (BSR). Effective June 6, 2005, the system will be modified to comply with HIPAA standards for details as follows:

- 837I – 450 details (the maximum number of details for Medicare)
- 837D – 50 details
- 837P – 50 details

Note: The changes in the number of details does not apply to paper claims. Although an increased number of details affects file size, the IHCP continues to accept as many as 5000 CLM segments per ST – SE.

Effective June 6, 2005, Web interChange will be updated to accommodate the new limitations.

Number of Units (Institutional) and Amounts (Institutional, Professional, and Dental)

Claims Submitted via Web interChange

Effective June 6, 2005, the length of the units field for institutional claim types expands from seven digits with no decimal places to 10 digits to allow for three decimal places. The units fields for physician and dental claim types do not change.

The length of the amount fields for all claim types expands to 10 total digits, including two decimal places, except for those submitted in the value information segment of the 837I transaction.

All existing negative value and formatting rules still apply.

835 Transaction

Amounts and units are reported on the 835 as they are received in the 837 transaction.

Uniqueness of the Attachment Control Number

When a provider submits electronic claims via Web interchange or an 837 transaction with attachments, the provider must submit an attachment cover sheet that includes the provider number, member's RID number, and the related Attachment Control Number (ACN), along with the attachment. The ACN is used to match the electronic claim with the paper attachment. The provider must assign a unique ACN to each claim. The ACN can be as many as 30 characters. The provider must maintain the unique ACN and use it only once. If the ACN specified in the 837 transaction is used more than once, the claim is rejected.

A request to void or replace a previously submitted claim with an attachment will require the provider to submit a new ACN.

National Provider Identifier

The National Provider Identifier (NPI) is a unique health identifier for health care providers who transmit any health information in an electronic format. The NPI resulted from a CMS project to develop a health care provider identification system to meet the needs of the Medicare and Medicaid programs and meet the criteria for a national standard.

The NPI is a 10-digit numeric identifier, which includes nine digits and a check digit in the tenth position. Use of the NPI reduces the need for providers to maintain multiple identification numbers. The IHCP currently assigns providers multiple identifiers based on the provider's type and provider's service locations.

The IHCP does not issue NPI numbers. An enumerator under the direction of the CMS issues the NPI numbers. Providers may begin applying for NPI numbers May 23, 2005.

More information about the NPI is available at www.cms.hhs.gov/hipaa/hipaa2. Additional information specific to the IHCP and the NPI is forthcoming.

Patient not Subscriber

Currently, the IHCP ignores patient loops 2000C and 2010CA because the IHCP members and subscribers are always the same as the patient.

With this system enhancement, the system will begin editing claims with a new Biller Summary edit (301) to ensure that the subscriber's Medicaid ID (Loop 2010BA Subscriber Name NM109) matches the patient's Medicaid ID (Loop 2010CA Patient Name NM109), if submitted.

Denied Service Lines on Crossover Claims

For Medicare Part B claims, Medicare sends denied service lines. Indiana*AIM* does not currently recognize the denied service lines on an otherwise paid claim. To obtain IHCP payment for these denied service lines, providers must send an adjustment request for the IHCP to deny the Medicare denied service lines. Then, the provider must submit a new IHCP claim for the denied service lines.

Effective June 22, 2005, the system will be modified so that it recognizes and denies the Medicare denied service lines on Medicare Part B crossover claims, and eliminates the need for providers to adjust the crossover claims.

As instructed in the IHCP 837 Institutional, Professional, and Dental Transactions companion guides, providers must submit the Medicare amounts (including Medicare paid, coinsurance, and deductible) at the service line for Medicare Part B crossover claims. Service lines sent without this information will be considered denied by Medicare; therefore, denied by the IHCP.

Medical Review Team

Medical Review Team (MRT) is an administrative program used to determine an applicant's eligibility for disability. The MRT consists of physicians and caseworkers that specialize in Medicaid eligibility determinations. These professionals make qualified decisions about whether new applicants meet the criteria for disability and establish medical reviews for current IHCP members. The MRT's decisions are based on medical findings that support pre-existing or current medical evidence that an applicant cannot perform substantive gainful employment (SGE).

Effective July 1, 2005 a provider may submit MRT claims using the 837P transaction, paper CMS-1500 claim form, and Web interChange claim submission. Detailed information about MRT claims processing will be published in an upcoming IHCP provider bulletin.

Pre-Admission Screening and Resident Review

Pre-Admission Screening and Resident Review (PASRR) is an administrative program that was mandated by government requirements and requires that all individuals with mental illness (MI) and/or mental retardation/developmental disabilities (MR/DD) who make Level II application must be admitted to a Medicaid-certified nursing facility. PASRR is a two-part program. Pre-admission screening (PAS) refers to the assessment and determination of member eligibility **prior** to admission to a nursing facility and resident review (RR) refers to the annual evaluation used to determine the necessity to continue services due to a change in condition.

Effective July 1, 2005 providers may submit PASRR claims using the 837P transaction, paper CMS-1500 claim form, and Web interChange claim submission.