IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201624 MAY 5, 2016

IHCP advises providers to update billing practices to get ready for *Core*MMIS

The Indiana Health Coverage Programs (IHCP) notified providers in *IHCP Bulletin* BT201539 that the existing claims processing system is being replaced with a new, more automated Medicaid management information system (MMIS) called *Core*MMIS. The new system is designed to more accurately and efficiently adjudicate claims according to IHCP coverage policies and national billing guidelines.

Providers are required to adhere to all policies and billing requirements outlined in IHCP provider *Bulletins*, *Banner Pages*, provider reference modules, and the *Medical Policy Manual*. Providers should also understand and comply with national guidelines for proper billing. The IHCP encourages providers to reference all resources to ensure claims are submitted correctly to prevent claim denials. Following the correct billing practices outlined in this bulletin will help providers prepare for transition to the new *Core*MMIS system.

Providers must bill on the correct claim types

Providers must bill on the correct claim type, based on their provider type and specialty and the service provided.

Separately reimbursed implantable DME must be billed on a CMS-1500 claim form or an 837P electronic transaction

The IHCP has identified certain implantable durable medical equipment (DME) devices that are reimbursed separately from the surgical procedures. When separate reimbursement is allowed, these devices must be billed by hospitals (provider type 01) and ambulatory surgical centers (ASCs) (provider type 02) on a *CMS-1500* claim form or an 837P electronic transaction. The new *Core*MMIS system enforces policy regarding services that allow for separate reimbursement and will deny claims that are billed for services not included under this policy.

As a reminder, the IHCP allows separate reimbursement for the following implantable DME items/services:

- Cardiac pacemakers, single chamber
- Cardiac pacemakers, dual chamber
- Cardiac pacemakers, other than single or dual chamber
- Implantable cardioverter-defibrillators

- Corneal tissue
- Implantable loop recorders
- Phrenic nerve stimulators
- Spinal cord stimulators
- New technology intraocular lenses (NTIOL)
- Vagus nerve stimulators
- Implantable infusion pumps, nonprogrammable
- Implantable infusion pumps, programmable

For more information, see the *Surgical Services*, *Durable and Home Medical Equipment and Supplies*, and *Vision Services* provider modules on the *Provider Reference Materials* page at indianamedicaid.com. For information on specific Healthcare Common Procedure Coding System (HCPCS) codes that have been identified for separate reimbursement, see the *Surgical Services Codes*, *Durable and Home Medical Equipment and Supplies Codes*, and *Vision Services Codes* on the *Code Sets* page at indianamedicaid.com.

Physical therapy providers must bill services on a CMS-1500 claim form or an 837P electronic transaction

The IHCP requires physical therapy providers (provider type 17, provider specialty 170) to bill therapy services on a *CMS-1500* claim form or an 837P electronic transaction. The practice of billing physical therapy using the institutional *UB-04* claim form or an 837I electronic transaction with Type of Bill Code 321 – *Home health* does not comply with correct billing guidelines. The new *Core*MMIS system strictly enforces edits linking claim type to provider type/specialty and will deny claims billed in this manner.

Rehabilitation Facilities must bill on the CMS-1500 claim form or an 837P electronic transaction

The IHCP enrolls two specialties under Rehabilitation Facilities (provider type 04):

- 040 – Rehabilitation Facility
- 041 – Comprehensive Outpatient Rehabilitation Facility (CORF)

The IHCP requires these specialties to bill services on a *CMS-1500* claim form or an 837P electronic transaction. The practice of billing services using the institutional *UB-04* claim form or 837I electronic transaction does not comply with correct billing guidelines. The new *Core*MMIS system strictly enforces edits linking claim type to provider type/specialty and will deny claims billed in this manner.

ASCs must bill on a UB-04 claim form or an 837I electronic transaction

The IHCP requires ASCs (provider type 02) to submit claims for surgical services using only the *UB-04* claim form or an 837I electronic transaction. ASCs should not submit claims on the *CMS-1500* claim form or an 837P electronic transaction. The only exceptions are Medicare crossover claims and implantable DME or items/services (see previous

list) for which the ASC is required to bill Medicare or the IHCP on the *CMS-1500* or 837P. The new *Core*MMIS will deny claims billed by ASCs on the *CMS-1500* claim form or via an 837P electronic transaction that are not defined as exceptions.

Only dental providers may submit ADA dental claim forms or 837D electronic transactions

The following types of providers may submit claims using the American Dental Association (ADA) dental claim form or an 837D electronic transaction:

- Endodontists
- General dentistry providers
- Orthodontists
- Oral surgeons
- Pediatric dentists
- Periodontists
- Prosthodontists

Professional dental services provided in hospital outpatient departments (including in acute care hospitals and ASCs) should be submitted on the ADA dental claim by the dental provider and not by the hospital. Hospital (provider type 01) and ASC (provider type 02) providers may not submit claims for professional dental services using the ADA dental claim form or an 837D electronic transaction. **Hospitals and ASC providers must use the *UB-04* to submit facility-related charges.** The new *Core*MMIS system strictly enforces edits linking claim type to provider type/specialty and will deny ADA claims billed by hospitals.

Other reminders about correct billing practices

Providers should comply with these billing practices to avoid claim denials.

Follow claim submission policy for Medicare Savings Programs benefits

Federal law requires that state Medicaid programs pay Medicare coinsurance or copayment and deductibles up to the Medicaid-allowed amount and/or premiums for certain elderly and disabled people through the Medicare Savings Programs. Eligible members are designated as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualified Individuals (QIs), or Qualified Disabled Working Individuals (QDWIs).

The benefits and claims payment policies for the various Medicare Savings Programs are:

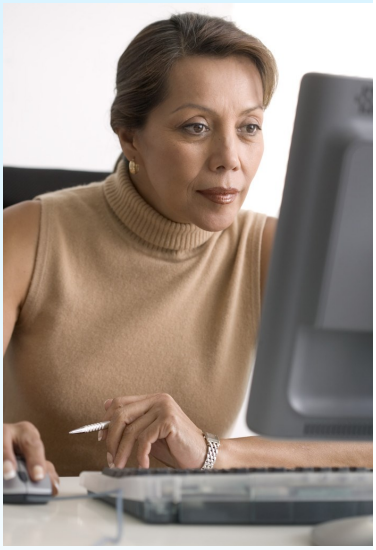
- *QMB-Only coverage:* The member's Medicaid benefits are limited to payment of the member's Medicare Part A (if not entitled to free Part A) and Part B premiums, as well as deductibles and coinsurance or copayment for Medicare -covered services only. **For members with QMB-Only coverage, claims for Medicare-covered services are submitted as crossovers. Claims for services not covered by Medicare should not be submitted to the IHCP.** Noncrossover claims, as well as services not covered by Medicare, will be denied by the IHCP as noncovered services.

- *QMB-Also coverage without HCBS waiver or End-Stage Renal Disease (ESRD) liability:* The member's Medicaid benefits include payment of the member's Medicare premiums, deductibles, and coinsurance or copayment for Medicare-covered services, as well as Traditional Medicaid benefits throughout each month of eligibility. **For members who have QMB-Also coverage without HCBS waiver or ESRD liability, claims for Medicare-covered services are submitted as crossover claims. Claims for services not covered by Medicare must be submitted to the IHCP as regular claims, not crossover claims, along with documentation supporting the Medicare denial**. Claims containing both Medicare-covered and noncovered services must be split and billed respectively as crossover and noncrossover claims.
- *QMB-Also coverage with HCBS waiver or ESRD liability:* The member's Medicaid benefits include payment of the member's Medicare premiums, deductibles, and coinsurance or copayment for Medicare-covered services as well as Traditional Medicaid benefits after the member's monthly HCBS waiver or ESRD liability is met. After the member's liability is met, the member becomes eligible for the full benefits covered by the Traditional Medicaid program, excluding coverage of prescription drugs covered by Medicare Part D. **For members who have QMB-Also coverage with HCBS waiver or ESRD liability, claims for Medicare-covered services are submitted as crossover claims. The coinsurance and deductible amounts are paid regardless of the balance of the member's HCBS waiver or ESRD liability. Claims for services not covered by Medicare must be submitted to the IHCP as regular claims, not crossover claims, along with documentation supporting the Medicare denial.** Claims containing both Medicare-covered and noncovered services must be split and billed respectively as crossover and noncrossover claims.
- *SLMB-Only coverage:* The member's Medicaid benefits are limited only to payment of the member's Medicare Part B premium. **Providers should advise members with SLMB-Only coverage that services are not covered by Medicaid.** Claims for services rendered to SLMB-Only members should not be billed to the IHCP.
- *SLMB-Also coverage without HCBS waiver or ESRD liability:* The member's Medicaid benefits include payment of the member's Medicare Part B premium, as well as Traditional Medicaid benefits, throughout each month of eligibility. **For members who have SLMB-Also coverage without HCBS waiver or ESRD liability, claims for Medicare-covered services are submitted as crossover claims. Claims for services not covered by Medicare must be submitted to the IHCP as regular, not crossover, claims, along with documentation supporting the Medicare denial.** Claims containing both Medicare covered and noncovered services must be split and billed respectively as crossover and noncrossover claims.

- *SLMB-Also coverage with HCBS waiver or ESRD liability:* The member's Medicaid benefits include payment of the member's Medicare Part B premium, as well as Traditional Medicaid benefits, after the member's monthly HCBS waiver or ESRD liability is met. After the member's liability is met, the

member becomes eligible for the full benefits covered by the Traditional Medicaid program, excluding coverage of prescription drugs covered by Medicare Part D. **For members who have SLMB-Also coverage with HCBS waiver or ESRD liability, claims for Medicare-covered services are submitted as crossover claims. Claims for services not covered by Medicare must be submitted to the IHCP as regular claims, not crossover claims, along with documentation supporting the Medicare denial.** Claims containing both Medicare covered and noncovered services must be split and billed respectively as crossover and noncrossover claims.

- *QI coverage:* The member's Medicaid benefits are limited only to payment of the member's Medicare Part B premium. **Providers should advise members with QI coverage that services are not covered by Medicaid.** Claims for services rendered to QI members should not be billed to the IHCP.
- *QDWI coverage:* The member's Medicaid benefits are limited only to payment of the member's Medicare Part A premium. **Providers should advise members with QDWI coverage that services are not covered by Medicaid.** Claims for services rendered to QDWI members should not be billed to the IHCP.



Providers who do not follow the claim submission policy may risk claim denial or recoupment through post-payment review. Please note that the coinsurance, copayment, or deductible will be reimbursed only for Medicaid-covered services.

Verify the dates of service on all claim details

Providers should include only valid dates of service (DOS) on all medical and dental claims. The current claims processing system validates and processes DOS on medical and dental claims at the detail level only. If one of the details contains an invalid DOS, only that detail denies. The provider must then rebill that line item or work through the adjustment process to obtain correct reimbursement.

The new *Core*MMIS system will validate and process DOS on medical and dental claims at both the header and detail levels. Therefore, if *any* detail on the claim contains an invalid DOS or a DOS not within the range entered at the header level, the entire claim will deny. The provider will have to correct and refile the claim for reimbursement consideration.

Providers must use full nine-digit ZIP Codes and taxonomy codes on claims

The IHCP reminds providers of the importance of using the full nine-digit ZIP Code for the service location and an appropriate taxonomy code when submitting claims for reimbursement consideration. For providers who have multiple IHCP Legacy Provider Identifiers (LPIs) with the same National Provider Identifier (NPI), the IHCP must establish a one-to-one relationship between the provider's NPI and the LPI/service location. The full nine-digit ZIP Code and taxonomy code are often required to establish a proper match.

Providers should make certain their provider enrollment profile contains the appropriate primary taxonomy code and any additional taxonomy codes that represent the provider's specialty. The taxonomy code submitted on the claim must match a taxonomy code listed in the provider profile.

Using proper taxonomy codes will be particularly important in establishing the NPI/service location match with the new *Core*MMIS. For a field-by-field description of each claim form, see the *Claims Submission and Processing* provider module on the *Provider Reference Materials* page at indianamedicaid.com.

Use the correct span dates on home health claims

Home health claims billed with an overhead occurrence code must include the span of consecutive dates in the appropriate fields, as well as separate detail lines for each date within the span: one line for each single DOS. For example, a claim billed with the overhead occurrence code for DOS February 1, 2015, through February 5, 2015, must contain five detail lines. The current claims processing system does not validate incorrect span dating with occurrence codes but will process the claim correctly, allowing only one overhead per day. The new *Core*MMIS claims processing system will validate the occurrence code span date with the line item DOS. If a *per diem* occurrence code is used, the claim must contain a detail for *each* date within the span, or the entire claim will deny.

Additionally, home health claims should not bill a span-date occurrence on one claim that duplicates an individual occurrence on another claim. For example, providers should not submit one claim with an occurrence and span dates of September 1, 2015, through September 10, 2015, and another claim with the DOS September 6, 2015. The September 6, 2015, claim is a duplicate of the prior span-date claim. The current claims processing system corrects this error and pays correctly. The new *Core*MMIS will not allow this practice and the duplicate will deny.

Institutional claims need both valid revenue codes and valid HCPCS codes

The current system does not validate a HCPCS code when it is submitted with a revenue code that is paid at a flat fee. With the implementation of *Core*MMIS, both the revenue code and the HCPCS code will be validated, even when reimbursement is based on the revenue code. If the revenue code is valid but the procedure code is not for an IHCP-covered service or is not linked to the revenue code billed per the UB Editor, the claim will deny.

Diagnosis codes must be valid for the DOS billed

Providers must ensure that *all* diagnosis codes reported on a *CMS-1500* claim form or an 837P electronic transaction are valid for the DOS billed. Although not all the diagnosis codes entered at the header (form locator 21 A-L on the *CMS-1500* claim form) may be used at the detail (form locator 24E on the *CMS-1500* claim form), all diagnosis codes must all be valid for the DOS.

The new *Core*MMIS system strictly enforces validity editing to all standard codes sets, such as diagnosis codes, and will deny claims with codes that are not valid on the DOS.

Billing reminders for LTC providers

- The IHCP reminds Long Term Care (LTC) providers that, as outlined in *405 IAC 5-24-9* through *405 IAC 5-24-14, 405 IAC 5-31-4,* and *4.5*, medical and nonmedical supplies, food supplements, nutritional supplements, infant formulas, legend and non-legend water products for irrigation or humidification, most skin protectants, sealants, moisturizers, and ointments are included in the facility's established *per diem* rate and may not be billed separately by the LTC facility or other provider.
- When the patient status is other than a discharge, the days billed associated with the accommodation revenue codes must match the "Through" DOS period on the claim. For example: A resident in an LTC facility from March 1–23 is hospitalized on March 24 and returned to the LTC facility on April 2. The LTC facility should bill March service dates as 23 days of *per diem* for the level of care (LOC). The status code is 30, because the member is still a resident of the LTC while in the hospital.

  If the same resident was discharged to home or to another facility from the hospital and did not return to the LTC facility on the anticipated date of April 2, the April bill should reflect discharge on April 2 with a status code of 02. Although the date of discharge is not reimbursed, the claim must show this date with the appropriate status code, reflecting the true disposition of the resident. The April bill would have April 2 through April 2 as the DOS, and one unit billed with the accommodation revenue code at the detail. For more in-depth billing information, including appropriate use of patient status codes in *UB-04* form locator 17 – Status, and *UB-04* form locator 6 – Statement Covers Period From/Through, see the *Long-Term Care* provider module and the *Long-Term Care Codes* on the *Code Sets* page at indianamedicaid.com.

  LTC providers do not receive reimbursement for the date of discharge. Therefore, it is imperative that LTC providers carefully complete the *UB-04* claim form to ensure that the "Through" DOS in form locator 6 on the claim form accurately reflects the actual date of discharge for the member.

The new *Core*MMIS system strictly enforces adherence to LTC coverage and billing policy. Providers that do not follow the LTC claim submission policy may risk claim denial or recoupment through post-payment review.

Billing reminders for transportation providers

The IHCP reimburses mileage and other add-on services, such as "accompanying parent" or "attendant only" when there is a payable base code on the claim. The provider must bill the base code along with the mileage, the accompanying parent or attendant code (if applicable), and the member's information. Providers must bill for all transportation services provided to the same member on the same DOS on one claim form. For detailed billing information, including applicable base and add-on services, see the *Transportation Services* provider module on the Provider Reference Materials page and the *Transportation Services Codes* on the *Code Sets* page at indianamedicaid.com.

Tips for billing CRNA claims

The IHCP reminds providers of billing guidelines for services furnished by a Certified Registered Nurse Anesthetist (CRNA).

- Do *not* use a CRNA modifier if the CRNA's individual NPI is used as the billing provider in field 24J of the CMS-1500 or electronic equivalent. CRNA modifiers should be reported on the claim *only* if the CRNA service is being reported using the anesthesiologist's provider number because the CRNA is not individually enrolled with the IHCP.
- Claims processed in the current system that include *both* a CRNA provider number *and* a CRNA modifier will underpay. The IHCP reimburses CRNA services at 60% of the Fee Schedule amount. The 60% multiplier is triggered by the presence of a CRNA provider number *or* a CRNA modifier. If a claim contains *both* a CRNA provider number and a CRNA modifier, the 60% multiplier will be applied twice – once for the CRNA provider number and a second time for the CRNA modifier, causing the claim to underpay.

  For example, if the Fee Schedule amount for a service is $100, that amount will multiplied by 60% (.60), based on the presence of the CRNA provider number ($100 X .60 = $60). Then that amount ($60) will be multiplied by 60% (.60) again based on the presence of the CRNA modifier ($60 X .60 = $36). In this example, the provider is underpaid by $24.
- CRNAs may *not* bill for anesthesia drugs, such as HCPCS code S0144 - *Injection Propofol, 10mg*. Anesthesia drugs are not separately billable by the CRNA or the physician. Reimbursement to the operative facility includes payment for all necessary drugs and supplies. See the *Anesthesia Services Codes* on the *Code Sets* page at indianamedicaid.com for a full list of reimbursable services for CRNA providers.

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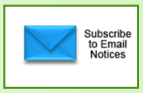

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