*Core*MMIS *bulletin*

Core benefits – Core enhancements – Core communications

INDIANA HEALTH COVERAGE PROGRAMS BT201669 OCTOBER 25, 2016

*Core*MMIS billing guidance: Part II

On December 5, 2016, the Indiana Health Coverage Programs (IHCP) will replace the current information processing system, Indiana*AIM*, with a new system called *Core*MMIS, which stands for Core Medicaid Management Information System. Along with *Core*MMIS, a new provider interface called the Provider Healthcare Portal (Portal) will replace Web interChange.

The new system is designed to more accurately and efficiently adjudicate claims in alignment with IHCP policies and procedures and national coding guidelines to prevent the improper payment of claims. Claims not following billing guidelines or claims for services inconsistent with IHCP policy will not process for reimbursement in *Core*MMIS as they may have in Indiana*AIM*. **Such claims will deny in *Core*MMIS, even though they may not have in Indiana*AIM*.**

The IHCP is revising billing guidance in some areas to support the new claims processing system. Providers should ensure that billing staff or vendors are familiar with new guidance issued through *Core*MMIS provider bulletins. *Core*MMIS billing guidance will apply to all claims, whether they are submitted through an 837 EDI transaction, through data entry in the new Portal, or by mail on paper claim forms. Providers must keep in mind that claims will transition to *Core*MMIS processing according to the transition time frames announced in *Core*MMIS *Bulletin* BT201662.

Outpatient billing

When billing outpatient services, the following billing reminders and revised guidance must be followed for successful adjudication of claims in *Core*MMIS:

- ***Core*MMIS requires a procedure code be included on a claim for any service billed with a revenue code, if that revenue code requires a procedure code per national coding guidelines.** The following instances are exceptions to this requirement.

- **The IHCP will continue to require a procedure code be billed with revenue code 260** – *IV Therapy-General*, even though this is not required by national coding guidelines.
- **With *Core*MMIS implementation, the IHCP will require a procedure code be billed with revenue code 270** - *Medical/Surgical Supplies and Devices-General*, even though this is not required by national coding guidelines.

- ***Core*MMIS includes an integrated uniform billing (UB) editor to automatically link procedure codes to the appropriate revenue codes.** The revenue codes listed in Table 1 are exceptions to this automatic linkage. The IHCP will continue to manually link procedure codes to the revenue codes in Table 1, even though these linkages may be inconsistent with national coding guidelines. Any such linkages will be announced via IHCP Provider Bulletins or Banner Pages and noted in the provider reference modules and code tables at indianamedicaid.com.

Table 1 – Revenue codes that may include procedure code linkages inconsistent with national coding guidelines

Revenue code	EOB description
274	Medical/surgical supplies and devices-prosthetic/orthotic devices
513	Clinic-psychiatric clinic
636	Pharmacy-extension of 025X-drugs requiring detailed coding
920	Other diagnostic services-general
929	Other diagnostic services-other diagnostic service
940	Other therapeutic services-general

- **Providers should continue to follow special IHCP billing guidance when billing the following Current Procedural Terminology (CPT®[1]) codes,** even though this guidance is inconsistent with national coding guidelines:
  - CPT code 94780 - *Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes* **must be billed with revenue code 460 - *Pulmonary function.***
  - CPT code 94781 - *Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes (List separately in addition to code for primary procedure)* **must be billed with revenue code 469 - *Other pulmonary function.***

Bilateral surgery billing and reimbursement

Bilateral surgery procedures are those performed during the same operative episode by the same provider. Effective with *Core*MMIS implementation, the IHCP will apply Centers for Medicare & Medicaid (CMS) guidelines when reimbursing for bilateral procedures. Reimbursement for the procedure codes will be based on the CMS National Physician Fee Schedule (NPFS) Relative Value File status indicators shown in Table 2.

Table 2 – NPFS Relative Value File status indicators

Indicator	Description
0	150% payment adjustment for bilateral procedures does not apply. Reimbursement is based on the lesser of the billed amount or the allowed amount.
1	150% payment adjustment for bilateral procedures applies. Reimbursement is based on the lesser of the billed amount or 150% of the allowed amount.
2	150% payment adjustment does not apply. The procedure is inherently bilateral and the reimbursement rate already includes payment for both sides. Reimbursement is based on the lesser of the billed amount or the allowed amount.
3	The usual payment adjustment for bilateral procedures does not apply. Reimbursement is based on the lesser of the billed amount or the allowed amount for each side.
9	Concept does not apply. Services performed with modifier 50 will systematically deny.

Providers are reminded that when billing for bilateral procedures, modifier 50 must be reported on the claim if the procedure code itself is not described as a bilateral procedure. If the procedure code is described as bilateral, modifier 50 should not be reported. The new explanations of benefits (EOBs) associated with modifier 50 in *Core*MMIS are shown in Table 3.

Table 3 – New modifier 50 EOBs effective with CoreMMIS implementation

EOB code	EOB description
4401	Modifier 50 "Bilateral" is invalid for the procedure billed. Please correct and resubmit.
6426	Modifiers 50, RT, and LT which were billed for this service are not billable together, please correct and resubmit.

Home health billing

Home health overhead occurrence codes

With the implementation of *Core*MMIS, providers must bill home health overhead with **occurrence code 73** (rather than with occurrence code 61, as was previously billed). The following are reminders regarding reporting home health overhead fees:

- Providers may report only one overhead per provider, per member, per day. Providers use the occurrence code, occurrence date, and occurrence span on the *UB-04* claim to indicate the appropriate overhead fee.
  - Occurrence code 73 indicates that one encounter with the member occurred on the date of service (DOS) shown or on each DOS during the span date shown.
  - If the DOSs billed are not consecutive, the provider should list each DOS and enter occurrence code 73 for each encounter.
  - If the DOSs billed are consecutive, and one encounter was provided per day, providers should enter occurrence code 73 for the span date.
- Providers that submit more than one *UB-04* claim for a multiple-member care situation should report the overhead on only one of the claims. As long as the overhead is reported for only one member, it does not matter which member.

Home health occurrence codes to bypass PA for post-discharge services

Providers are reminded that per *Indiana Administrative Code (IAC) 405 IAC 5-16-3*, members who are discharged from a hospital are allowed home health services without prior authorization (PA) for 30 calendar days following discharge, if the physician orders the service in writing prior to the member's discharge and the member is homebound. Qualifying services are limited as follows:

- Registered nurse (RN), licensed practical nurse (LPN), or home health aide services not to exceed 120 units
- Any combination of therapy services not to exceed 30 units

Providers must bill home health services that meet the parameters to bypass PA **with occurrence code 42** (rather than with occurrence code 50, as was previously billed). Providers should bill occurrence code 42 with the corresponding date of discharge. When a provider bills for services exceeding the limitations and no PA is on file for the excess units, *Core*MMIS will automatically deny the excess units.

Hospice services billing

With *Core*MMIS implementation, several changes will be made to billing requirements for hospice services. Billing instructions have been adapted to include the more descriptive occurrence codes and patient discharge status codes available.

- Service intensity add-on (SIA) revenue codes 551 or 561 must include a **patient discharge status code of 20, 40, 41, or 42** (previously only code 20 was used) [in form locator 17 on paper claims].
- SIA revenue codes 551 or 561 must continue to include **occurrence code 55** and the date of death/discharge [in form locator 32 on paper claims].
- Revenue codes 651 and 653 must include **occurrence code 55** (rather than code 51, as was previously billed) and the date of death/discharge [in form locator 32 on paper claims].
- Revenue codes 651 and 653 must include **occurrence code 42** (rather than code 51, as was previously billed) for live discharges [in form locator 32 on paper claims].

Renal dialysis services billing

With the implementation of *Core*MMIS, there will be no changes to existing IHCP policy, reimbursement, or billing instructions for renal dialysis and end-stage renal disease (ESRD) services. *Core*MMIS will, however, strictly enforce existing policy. Providers should review the IHCP *Medical Policy Manual* and *Renal Dialysis Services* provider reference module for policy and related billing guidelines.

Dialysis composite rate

Providers are reminded that the composite rate for renal dialysis is the charge for the actual treatment or dialysis session. Routine laboratory charges are included in the composite rate for hemodialysis or peritoneal dialysis and, as such, should not be billed separately. The composite rate also includes all durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis.

- Services included in the composite rate that are reported on the same claim for the same DOS that a dialysis composite rate revenue code is billed will deny with EOB 3317 – *The procedure billed on this detail is included in the composite rate revenue code billed for this service. It is not separately reimbursable.*
- Services included in the composite rate that are reported on a different claim for the same DOS that a dialysis composite rate revenue code is billed will deny with EOB 6312 – *ESRD procedure being billed for this DOS as all-inclusive to a Medicaid composite rate service already paid for the same DOS.*
- Previously paid claims for services included in the composite rate revenue code that is subsequently billed for a DOS will be recouped and post with EOB 6314 – *Previously paid ESRD procedure not payable on the same date of service as a Medicaid composite rate revenue code.* The current claim paid for the composite rate revenue code for the same DOS will post with EOB 6313 – *A previously paid ESRD procedure is being recouped as all-inclusive to a Medicaid composite rate revenue code when both rendered on the same date of service.*

Nonroutine medically necessary laboratory services

The IHCP does cover, and separately reimburse, nonroutine laboratory services for the same DOS that a dialysis composite-rate revenue code is paid, if medical justification is indicated. When billing for these services, providers

must append modifier **AY** to the procedure code on the claim and attach medical documentation to indicate the service was not routine and was medically necessary. When allowable procedure codes are billed on the same DOS as a dialysis composite-rate revenue code, the claim will suspend with EOB 3318 – *ESRD procedure requires attachment indicating medical necessity*. Note that the modifier **AY** is not required on crossover claims.

Composite-rate revenue codes

Providers are limited to one unit of service per DOS for the revenue codes in Table 4. Each of these revenue codes represents a dialysis session, and no more than one unit of service is reimbursable per revenue code, per DOS. Providers must bill each date-specific service separately on the *UB-04* claim; span dates are ***not*** allowed. For example, if a patient receives 15 dialysis treatments in a month, the provider should enter 15 detail lines of revenue code 821 on the *UB-04* claim for each specific DOS. This billing guideline is also applicable for all other services provided during the month.

- Claim detail lines reporting more than one unit will be cut back to one unit and will post with explanation of benefits (EOB) 4020 – *Units billed exceed allowable units for this service*.
- Claims reporting more than one dialysis composite rate revenue code for the same DOS will deny with EOB 6311 – *A Medicaid composite rate service has already been paid for the same DOS.*

Table 4 – Revenue codes for which providers are limited to one unit of service per DOS

Revenue code	Description
821	Hemodialysis/composite or other rate
829	Other outpatient hemodialysis
830	Peritoneal dialysis, outpatient or home, general classification
831	Peritoneal dialysis/composite or other rate
841	CAPD/composite or other rate
851	CCPD/composite or other rate
881	Ultrafiltration

Dialysis diagnosis codes

One of the ICD-10 diagnosis codes in Table 5 must be listed as the principal diagnosis for any dialysis service submitted to the IHCP for reimbursement consideration. This listing is maintained in the *Renal Dialysis Services Codes* table on the *Code Sets* page at indianamedicaid.com.

Table 5 – ICD-10 diagnosis codes for renal dialysis

Diagnosis code	Description
N17.0	Acute kidney failure with tubular necrosis
N17.1	Acute kidney failure with acute cortical necrosis
N17.2	Acute kidney failure with medullary necrosis
N17.8	Other acute kidney failure
N17.9	Acute kidney failure, unspecified
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3	Chronic kidney disease, stage 3 (moderate)
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease
N18.9	Chronic kidney disease, unspecified
N19	Unspecified kidney failure

Stay informed

The IHCP appreciates the quality services providers offer our members and is committed to working closely with the provider community during this transition. It is critical that providers stay informed as *Core*MMIS implementation approaches. All *Core*MMIS provider bulletins are posted on the Indiana *Core*MMIS page at indianamedicaid.com. Sign up for IHCP Email Notifications to be alerted when future bulletins are released. Direct questions to your HPE Provider Relations field consultant or email incoremmis2015im@hpe.com.

QUESTIONS?

For additional questions about *Core*MMIS, email incoremmis2015im@hpe.com.

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