PROVIDER *news*

INDIANA HEALTH COVERAGE PROGRAMS NL201310 OCTOBER 2013

Reminder: Charging members for services covered by the IHCP is against federal and state regulations

Federal and state regulations prohibit providers from charging Indiana Health Coverage Programs (IHCP) members, or the families of members, for any amount not paid by the IHCP for covered services. Per the terms of the IHCP Provider Agreement, providers are required to accept IHCP payment as payment in full for the covered services provided.

The IHCP allows providers to charge members for some services when certain requirements have been met. For example, providers may charge members for copayment amounts assessed by the IHCP. Providers are not required to obtain advance notice of noncoverage or waiver to charge and collect these IHCP copayments. See *Chapter 4* of the *IHCP Provider Manual* for more information.

INSIDE STORIES

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A provider may charge a member for services the member wishes to receive that are not covered by the IHCP. However, to charge for these noncovered services, the provider must notify the member **before** providing the service that the service is not covered by the IHCP. If the member wishes to receive the service knowing it will not be covered, he or she must have agreed to accept full financial responsibility for that service. Provider notification and member agreement must be clearly documented in writing and available for inspection by the IHCP on request.

continued

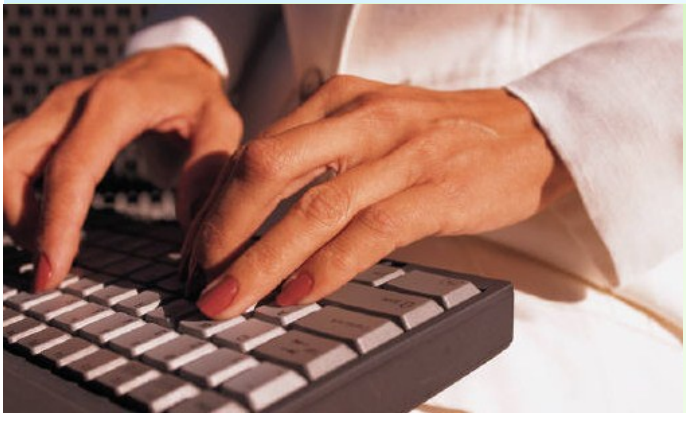
Services the IHCP does not cover

Services may be noncovered for a variety of reasons, including, but not limited to, the following:

- The IHCP excludes the service, such as a cosmetic procedure, from coverage
- The service is not covered under the member's benefit package. Examples include:
  - Services that are not related to the pregnancy for Package B members
  - Services that are not considered family planning for members of the Family Planning Eligibility Program
  - Nonemergency services for Package E members
- The service is limited to a specified number of days, units, or visits, and prior authorization (PA) is not available for services beyond the limit
- The service requires PA, and the request for PA was denied
- The service requires a referral or authorization from the member's primary medical provider or managed care entity (MCE), and the authorization was denied

Spend-down is not considered a noncovered service or a copayment. Spend-down is a monthly member deductible. Providers may not collect a spend-down amount until after the claim has processed. Providers may collect only the amount indicated to the right of adjustment reason code (ARC) 178 on the Remittance Advice (RA). If ARC 178 is not listed but the provider sees a spend-down denial message, the provider must contact Customer Service to resolve the claim.

See *Charging Members for Noncovered Services* in *Chapter 4* of the *IHCP Provider Manual* for a complete description of the policy. Providers should also see *Chapter 2* and *Chapter 8* of the *IHCP Provider Manual* to become familiar with coverage limitations.



Sign up for the EHR incentive program

Incentive payments for the Electronic Health Records (EHR) initiative amount to more than $124 million since the program's introduction in May 2011. A total of 1,771 eligible professionals and 109 eligible hospitals have benefited from these payments. For more information about EHR, see the EHR Incentive Program page at indianamedicaid.com.

Don't miss the 2013 IHCP Annual Provider Seminar October 22-24!

The Office of Medicaid Policy and Planning (OMPP) and Hewlett Packard (HP) Enterprise Services invite Indiana Health Coverage Programs (IHCP) providers to attend the 2013 IHCP Annual Provider Seminar October 22-24, 2013, in Indianapolis. There is no cost for the seminar.

The seminar features three full days of important information, including program overviews and billing, as well as information about Program Integrity and member eligibility. Sessions will be led by HP, ADVANTAGE Health Solutions℠, Anthem, Managed Health Services (MHS), and MDwise. See the 2013 IHCP Annual Provider Seminar page at indianamedicaid.com for the full seminar lineup. Sign up today!

Partial code freeze planned for ICD-10

The Centers for Medicare & Medicaid Services (CMS) publication, *Partial Code Freeze for ICD-9 and ICD-10 Finalized*, explains the partial code freeze related to the implementation of ICD-10. The following outlines what will and will not be affected by the freeze and the dates that apply to each.

- The last regular, annual updates to ICD-9-CM and ICD-10 code sets were made October 1, 2011.
- On October 1, 2012, and October 1, 2013, there were only limited code updates to both the ICD-9-CM and ICD-10 code sets.
- On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section *503(a) of Pub. L. 108-173*. (There will be no further updates to ICD-9-CM, as it will no longer be used for reporting.)
- On October 1, 2015, regular updates to ICD-10 will begin.

Indiana Health Coverage Programs will **not** institute a freeze on claims processing, enrollment of providers, eligibility, or the Help Desk. For more information about ICD-10, see the ICD-10 Information page at indianamedicaid.com.

Sign up for the ICD-10 presentations at the 2013 IHCP Annual Provider Seminar

ICD-10 is just around the corner. When you sign up for the 2013 IHCP Annual Provider Seminar, be sure to sign up to attend at least one ICD-10 presentation. Each of the three sessions has a different focus, and each will include time for questions and answers. In addition, the Indiana Medicaid ICD-10 team will be available in the Web Room (where providers get help with Web interChange claim submissions) following each presentation to answer ICD-10 questions.

- **October 22, 2013, 11:15 – 12:15 a.m. – ICD-10 Testing and Diagnosis-Related Group –** This session provides vendor testing updates and information from the Centers for Medicare & Medicaid Services (CMS) about provider testing. The second part of the presentation covers the selection, testing, and implementation of the 3M™ All-Patient Refined Diagnosis-Related Group (APR-DRG). A representative of 3M™ is scheduled to answer APR-DRG questions.
- **October 23, 2013, 1:45 – 2:45 p.m. – ICD-10 Medical Policy Changes –** Presented by ICD-10 Medical Policy Analyst Geneane White , this session covers the process of policy review and revision, along with information about policies that will be updated as part of the ICD-10 implementation.
- **October 24, 2013, 10 – 11 a.m. – What to Expect on October 1, 2014 –** This session is an overview of ICD-10 and the changes that will occur when ICD-10 implements October 1, 2014.

Include these sessions in your selections when you register for the 2013 IHCP Annual Provider Seminar.

Answers to your ICD-10 questions

Q I am a pricing lead for Medicaid institutional pricing and want to know if the Indiana Health Coverage Programs (IHCP) intends to use the All Patient Refined-Diagnosis-Related Group (APR-DRG) for dates of service on or after October 1, 2014. If the member is admitted before October 1, 2014, should the claim continue to price using All Patient-Diagnosis-Related Group (AP-DRG)?

A The APR-DRG (grouper) will be used for ICD-10 but will not replace the AP version 18 now used for dates of service (DOS) before the ICD-10 effective date of October 1, 2014. The IHCP does not plan any updates to the AP version 18 after October 1, 2013. (See the *3M™ APR-DRG for ICD-10* section of the ICD-10 Decisions page at indianamedicaid.com.)

The IHCP now uses the FROM date of service for inpatient (I) and inpatient crossover (A) claim types; however, with ICD-10 implementation, this practice will change to use of the THROUGH date. (See the *ICD-10 span-date logic* section of the ICD-10 Decisions page at indianamedicaid.com.)

Q What is the date of service (DOS) that will be used for APR-DRG testing?

A HP will test with software vendors and clearinghouses but not directly with providers. It is the responsibility of the vendor or clearinghouse to coordinate testing with the provider. APR-DRG testing dates are March – June 2014. The date of service (DOS) that will be used has not yet been decided. This information will be available in upcoming IHCP publications.

Q How will you advise facilities to bill newborn claims? Will you require a birth-weight diagnosis, or can the facilities bill value code 54 and the baby's weight, or both?

A We will continue to require the birth-weight diagnosis to indicate the baby's birth weight.

Q Will the pricing methodologies now in place for AP-DRG version 18 pricing facilities be the same once they move to APR-DRG, or will they change? If they will change, how will they change?

A The process will be the same. We are not changing our reimbursement methodology. The rate information will not be available until after all policy decisions have been made and the base rate and relative weights have been determined. Once these decisions have been made, the information will be published in IHCP publications and on the ICD-10 Decisions page at indianamedicaid.com. Myers and Stauffer, the State's rate-setting contractor, assigns the rates.

Q Will Indiana price interim claims (interim claims can be identified by the bill type and discharge status – example: 112, discharge status 30)?

A We allow interim claims in special circumstances. For example, if the claim groups to an inpatient psychiatric, burn, or rehabilitation level of care (LOC) DRG, we allow interim claims. Regular inpatient non-LOC DRG claims cannot be billed as interim. The policy for AP-DRG will not change. The billing rules for inpatient claims for the new APR-DRG have not been fully determined.

RECENTLY PUBLISHED TO THE IHCP WEBSITE

PROVIDER MANUAL UPDATES

The Revision History in each manual (or chapter) provides detailed information about updates.

- *IHCP Provider Manual* – The following chapters of the manual has been updated:
  - Chapter 1 – *General Information*
  - Chapter 12 – *Financial Services*
- *590 Program Provider Manual*
- *Hospice Provider Manual*

BULLETIN

- BT201341 – The IHCP to implement ICD-10-related changes
- BT201342 – 2013 IHCP Annual Provider Seminar scheduled for October 22-24 in Indianapolis
- BT201343 – Changes to the Preferred Drug List
- BT201344 – Additional coverage and billing information for the July quarterly CPT/HCPCS code updates
- BT201345 – The OMPP announces changes to Indiana Medicaid eligibility

NEWS FROM RECENT BANNER PAGES

- Pharmacy claims mass adjusted for Medicare Part D/ dually eligible members
- Billing guidance clarified for initial evaluations for physical/occupational therapy in home settings
- Pharmacy claims for blood factor mass adjusted
- FFS vaccine administration claims denied in error
- Social Security numbers redacted on Web interChange
- Updated diagnosis codes for routine foot care
- FQHCs/RHCs may resubmit claims for Family Planning Eligibility Program
- ICD-10 interim implementation
- HCPCS code K0108 added to specialty group 250
- Update regarding revenue code 483
- CPT code 52287 linked to revenue code 490
- The IHCP to cover HCPCS code V2531
- New coverage and reimbursement for Sclerotherapy
- Unit restriction of one removed for CPT code 95017
- PA no longer required for initial evaluations for speech therapy
- Bed-hold days paid in error to be mass adjusted

FOR MORE INFORMATION

- Contact your Provider Relations Field Consultant.
- IHCP Provider Quick Reference – This reference contains a complete list of addresses, telephone numbers, and fax numbers for the IHCP and IHCP vendors.
- Subscribe to IHCP E-mail Notifications.
- Contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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