CMS-1500 Billing and Reimbursement Fee-for-service

HP Provider Relations/October 2014
Agenda

• Objectives
• Provider types using CMS-1500
• Filing Claims
  - 837P
  - Web interChange
  - Paper
  - Adjustments
• Fee Schedules
• Code Sets
• Claim Billing Guidelines
• Helpful Tools
• Q&A
Objectives

• At the end of this session, providers should understand:
  − What provider types bill on the CMS-1500 claim form
  − How CMS-1500 claims are billed and reimbursed
  − General billing and coverage guidelines for many of the professional services billable to the Indiana Health Coverage Programs (IHCP)
Provider Types Using the CMS-1500
Providers Types Billing on CMS-1500 or 837P

- Advanced practice nurses – Midwife services, nurse practitioner services, nurse anesthetist services, and clinical nurse specialists
- Audiologists – Audiology services
- Case managers – Care coordination services
- Certified registered nurse anesthetists (CRNAs)
- Chiropractors – Chiropractic services
- Clinics – Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
- Comprehensive outpatient rehabilitation facilities
- Dentists – Oral surgery
- Diabetes self-management services
- Durable medical equipment (DME), home medical equipment (HME), and supply dealers – DME, medical supplies, and oxygen
Providers Types Billing on CMS-1500 or 837P

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service providers
- Freestanding radiology facilities – Radiological services, professional component or global
- Hearing aid dealers – Hearing aids
- Independent diagnostic testing facilities
- Laboratories – Lab services, professional component
- Mental health providers – Medicaid Rehabilitation Option (MRO) services, outpatient mental health services, partial hospitalization
- Mid-level practitioners – Anesthesiology assistant services, physician assistant services, independent practice school psychologists, and advanced practice nurses under Indiana Code (IC) 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
  - Billing under the supervising physician rendering National Provider Identifier (NPI)
Providers Types Billing on CMS-1500 or 837P

- Opticians – Optical services
- Optometrists – Optometric services
- Pharmacies – Supplies
- Physicians, medical doctors, and doctors of osteopathy – Anesthesiology services, lab services, professional component, medical services, mental health services, radiology services, renal dialysis services, surgical services
- Podiatrists – Podiatric services
- Public health agencies – Medical services
- School corporations – Therapy services: physical, occupational, speech, mental health
- Therapists – Therapy services: physical, occupational, speech, audiology
- Transportation provider – Transportation services, including hospital-based ambulance services
- Waiver providers – Waiver services
CMS-1500 Claim Billing
Types of *CMS-1500* Claims

- **837P** – Electronic transaction
  - Companion Guide available at

- **Web interChange**

- **Paper claim** (*CMS-1500* version 02/12)

- **Replacement/Adjustment request** (for a previously paid claim)
CMS-1500 Paper Claim Billing
Effective April 1, 2014, the Indiana Health Coverage Programs (IHCP) accepts only the revised version of the CMS-1500 (02/12).

New claim form includes the following changes:

- Additional fields for up to 12 diagnosis codes
- Increased field length for the ICD diagnosis code for up to seven characters with no decimal point
- An ICD indicator (to reflect ICD-9 or ICD-10 code set)
- Accommodations for up to four related diagnosis code references, with letters A-L corresponding to the applicable diagnosis codes in fields 21 A-L
- Block 30 no longer required
CMS-1500 Paper Claim (02/12)
CMS-1500 Paper Claim (02/12)
The IHCP to transition to the new version of the CMS-1500 paper claim form
BT201353 – Line-by-line instructions

CMS-1500 (02/12) claim form instructions

The instructions outlined in this bulletin are effective for paper claim submissions on the revised CMS-1500 (02/12) claim form. A sample of the new claim form is included in this bulletin for reference.

Note that some form fields are required while others are optional. Table 2 describes each claim form field and uses **bold** type to indicate if a field is “**required**” or “**required, if applicable**.” Fields that are “optional” and “not applicable” are displayed in normal type. Instructions applicable to particular provider types are included. The table describes each form locator by referring to the number found in the left corner of each box on the CMS-1500 (02/12) claim form. All form locator fields with changes are noted with asterisks (*).

*These instructions apply to the IHCP guidelines only and are not intended to replace instructions issued by the NUCC. The NUCC instruction manual can be found at [nucc.org](http://nucc.org).*

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Table 2 - CMS-1500 (02/12) claim form field descriptions

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>Narrative Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INSURANCE CARRIER SELECTION – Enter X for Traditional Medicaid. <strong>Required</strong></td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1) – Enter the IHCP member identification number (RID). Must be 12 digits. <strong>Required</strong></td>
</tr>
<tr>
<td>2</td>
<td>PATIENT’S NAME (Last Name, First Name, Middle Initial) – Enter the member’s last name, first name, and middle initial obtained from the Automated Voice Response (AVR) system, electronic claim submission (ECS), Omni, or Web InterChange verification. <strong>Required</strong></td>
</tr>
<tr>
<td>3</td>
<td>PATIENT’S BIRTH DATE – Enter the member’s birth date in MMDDYY format. Optional. SEX – Enter X in the appropriate box. Optional.</td>
</tr>
<tr>
<td>4</td>
<td>INSURED’S NAME (Last Name, First Name, Middle Initial) – Not applicable.</td>
</tr>
</tbody>
</table>
# CMS-1500 Adjustment Request

**CMS - 1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST**

**INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION**

Mail completed requests to: HP - Adjustments, P.O. Box 7265, Indianapolis, IN 46207-7265

(1) PROVIDER NPI or LPI and Service Location:

**PROVIDER NAME/ADDRESS/ZIP+4:**

<table>
<thead>
<tr>
<th>Taxonomy Code:</th>
</tr>
</thead>
</table>

(2) REASON FOR ADJUSTMENT:

(Check appropriate Box)

- [ ] Change TPL Amt.
- [ ] Change Patient Deductible Amt.
- [ ] Offset or Refund of entire claim amount
  - (Please check block 11)
- [ ] Change information as indicated in blocks 14-18
- [ ] Medicare Adjustment (Attach all EOMBs that apply to this adjustment)

(3) CLAIM NUMBER (ICN) | (4) MEMBER ID NO. | (5) DATE OF SERVICE From | Thru | (6) Referring NPI/Taxonomy |
|------------------------|------------------|--------------------------|------|---------------------------|

(7) MEMBER NAME | (8) AMOUNT PAID | (9) REMITTANCE ADVICE DATE |
|----------------|----------------|---------------------------|
Web InterChange – Copy/Void/Replace

![Professional Claim Form](image)
Fee Schedule

• Access the fee schedule to determine:
  - Reimbursement rates
  - Pricing effective dates
  - Prior authorization requirements
  - Program coverage

• Applies to Traditional Fee-for-Service Medicaid and Care Select
Accessing the Fee Schedule
Accessing the Fee Schedule

IHCP Fee Schedule - Copyright Agreement

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Accept  Decline
Accessing the Fee Schedule

**Fee Schedule - Last Updated 06-24-2014**

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The Indiana Health Coverage Programs (IHCP) Fee Schedule provides information regarding all CPT®-4 Procedure codes, Healthcare Common Procedure Coding System (HCPCS), and American Dental Association (ADA) codes currently recognized by the IHCP. This Fee Schedule is intended for use by providers that bill services on the CMS-1500 Claim Form and the Dental Claim Form only. The information contained on this Fee Schedule does not pertain to providers that use the UB-04 or Pharmacy Claim Form. Information for UB-04 and pharmacy billers can be found in Chapter 7, Reimbursement Methodologies and Chapter 9 – IHCP Pharmacy Services Benefit of the IHCP Provider Manual.

This is an interactive site that allows you to View the Entire Fee Schedule, Search by Procedure Code, Procedure Code Range, Procedure Code Description, or search by keywords (for example, tooth, surgery, and so on).
Accessing the Fee Schedule

Enter a Procedure Code in the text box provided and press the Submit button to start your query. You may also enter up to 4 modifiers to further refine your query.

Procedures Code: S4762  
Modifiers:  
Submit

Search by Procedure Code Description
To search for Procedure Code Descriptions containing specific text, select how you would like for us to search for that text and then enter the text. The result of your selections should make a complete sentence. For example, selecting Contains and keying in the word surgical, would return all entries containing the word surgical, regardless of the relative placement of that word within the description. The resulting sentence (“Find any Procedure where the Description contains surgical”) describes what you want to do. You may also enter up to 4 modifiers to further refine your query.

Find any Procedure where the Description: Contains  
Modifiers:  
Submit

Search by Procedure Code Range
Enter a beginning Procedure Code and then an ending Procedure Code in the text boxes provided and click on the Submit button to start your query. You may also enter up to 4 modifiers to further refine your query.

Beginning Procedure Code:  
Ending Procedure Code:  
Modifiers:  
Submit

Code values are described on the Fee Schedule Instructions page. View ASC Code Pricing information by clicking on the ASC Code, or you can view the entire ASC Pricing Table. View a chart of reimbursement percentages for manually priced CPT codes with effective dates for UB-04. View a chart of reimbursement percentages for manually priced CPT codes with effective dates for CMS-1500.
Accessing the Fee Schedule

* Code values are described on the Fee Schedule Instructions page.

View ASC Code Pricing information by clicking on the ASC Code, or you can view the entire ASC Pricing Table.

View a chart of reimbursement percentages for manually priced CPT codes with effective dates for UB-04.

View a chart of reimbursement percentages for manually priced CPT codes with effective dates for CMS-1500.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Mod 1</th>
<th>Mod 2</th>
<th>Mod 3</th>
<th>Mod 4</th>
<th>Taxonomy Code</th>
<th>Program Code</th>
<th>Program Coverage</th>
<th>Pricing Indica</th>
<th>Pricing Effective Date</th>
<th>Pricing End Date</th>
<th>Pricing Modifier</th>
<th>Waiver ASC Type</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>94762</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>ALL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Units Min: 0  Units Max: 0  Fee Schedule Amt: $35.00  Anesthesia Base Unit: 0  Modified Desc: NONINVASIVE EAR OR PULSE
Understanding Fee Schedule Instructions

IHCP Fee Schedule - Instructions

Procedure Codes are listed in ascending order followed by alpha procedure codes. The information provided is reflective of the most current allowed rate for all procedure codes pertinent to CMS 1500, 837 Professional and Dental billers. The IHCP Fee Schedule is "at a minimum" updated monthly. To determine the allowed rate for a given procedure code, perform the following steps:

- Find the procedure code on the Fee schedule.
- Modifiers displayed under the headings Mod1, Mod2, Mod3, and Mod4, and the taxonomy should be considered part of the procedure code combination. If you are billing with a procedure code and modifier, or a procedure code, modifier and/or taxonomy combination, look for the procedure code combination on the fee schedule.
- If the procedure code has a Normal or Manual pricing indicator, there will be no fee schedule amount listed. Refer to the Indiana Health Coverage Programs Provider Manual for questions concerning Manual pricing.

The Program Coverage Value descriptors are:

1. Traditional Medicaid and Hoosier Healthwise covered.
2. Traditional Medicaid and Hoosier Healthwise covered, with the exception of Package C.
3. Package C covered only.
4. Not covered.

The Program PA Values descriptors are:

1. PA required for Traditional Medicaid and Hoosier Healthwise.
2. PA required for Traditional Medicaid and Hoosier Healthwise, with the exception of Package C.
3. PA only required for Package C.
4. PA not required.
Provider Code Sets
Provider Code Sets

The following provider types have specific code sets:

• Chiropractic
• Durable Medical Equipment
• Hearing Services
• HIV Care Coordination
• Home Medical Equipment
• Optician
• Optometrist
• Transportation
• Vision
Viewing Provider Code Sets
Viewing Provider Code Sets

**PROVIDER CODE SETS**

The Provider Code Set tool lists codes for the following provider types:

- Chiropractic
- Durable Medical Equipment (DME)
- Hearing Services
- HIV Care Coordinator
- Home Medical Equipment (HME)
- Optician
- Optometrist
- Transportation

Note: If there is no code set listed for your enrolled provider specialty, the following information does not apply to you at this time.

[Launch Provider Code Sets]
Viewing Provider Code Sets

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[Accept] [Decline]
Viewing Provider Code Sets

Special Note: Providers must only bill for services they are licensed and/or certified to perform under applicable Federal and State laws and regulations, and IHCP rules and policies

Chiropractic - Effective July 1, 2003
- Chiropractic Updated 5/6/2010

Transportation - Effective July 1, 2004
- Transportation Updated 5/6/2010
- For additional information see IHCP Newsletters:
  - May 2004
  - September 2004

Vision Services Code Sets - Effective October 1, 2004
- Optician Updated 08/15/2011
- Optometrist Updated 08/02/2011

Hearing Services - Effective October 1, 2004
- Hearing Services Code Set Updated 08/02/2011

HIV Care Coordinator - Effective October 1, 2004
- HIV Care Coordinator Updated 05/06/2010

Durable Medical Equipment (DME) - Effective October 30, 2007
- Durable Medical Equipment (DME) Updated 04/02/2012

Home Medical Equipment (HME) - Effective January 1, 2007
- Home Medical Equipment (HME) Updated 01/27/2011
# DME Code Set

**Durable Medical Equipment (DME) Code Set**

**DME Providers (250)**

**Last Updated March 25, 2013**

A listing on this table does not necessarily indicate coverage. Please refer to the IHCP newsletters, banners, and bulletins and the IHCP Fee Schedule for update to coverage and benefits information.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94760</td>
<td>NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; SINGLE DETERMINATION</td>
</tr>
<tr>
<td>94762</td>
<td>NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; BY CONTINOUS OVERNIGHT MONITORING</td>
</tr>
<tr>
<td>94772 TC</td>
<td>CIRCADIAN RESPIRATORY PATTERN RECORDING (PEDIATRIC PNEUMOGRAM), 12 TO 24 HOURS CONTINUOUS RECORDING , INFANT, TC = TECHNICAL COMPONENT</td>
</tr>
<tr>
<td>A4206</td>
<td>SYRINGE WITH NEEDLE, STERILE 1CC, EACH</td>
</tr>
<tr>
<td>A4207</td>
<td>SYRINGE WITH NEEDLE, STERILE 2CC, EACH</td>
</tr>
</tbody>
</table>
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Evaluation and Management Codes

*Traditional and Care Select Members*

- New patient office visits are limited to one visit per member, per billing provider – once every three years
- Reimbursement is available for office visits to a maximum of 30 per rolling 12-month period, per IHCP member, without prior authorization (PA), and subject to the restrictions in Section 2 of 405 IAC 5-9-1
- Per 405 IAC 5-9-2, office visits should be appropriate to the diagnosis and treatment given, and properly coded
Chiropractors

Traditional and Care Select Members

- IHCP limits chiropractic services to 50 per member, per calendar year
  - The IHCP reimburses for no more than five office visits out of the 50 total visits
- Package C members are allowed five office visits and 14 therapeutic physical medicine treatments per member, per calendar year
Chiropractors

*Traditional and Care Select Members*

- The following are covered codes for office visits:
  - 99201, 99202, 99203, 99211, 99212, 99213
- The following are covered codes for manipulative treatment:
  - 98940-98943

*Note: Services denied by Medicare must be billed as Medicaid primary claims and be submitted with the MRN*
Anesthesia

*Traditional and Care Select Members*

- Use Current Procedural Terminology (CPT®) codes 00100-01999 (see *IHCP Provider Manual Chapter 8* for more information)
- One unit = 15 minutes
- Bill the actual time in minutes and include it in field 24G
- Additional units are allowed based on a patient’s age, and when billing for emergency services (bill using procedure code 99140)
- See *IHCP Provider Manual Chapter 8* for appropriate billable CRNA codes
# Anesthesia

*Traditional and Care Select Members*

## Modifiers for medical direction

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
</tr>
<tr>
<td>QS</td>
<td>Monitored anesthesia care services</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA with medical direction by a physician</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA without medical direction by a physician</td>
</tr>
</tbody>
</table>

*Note:* CRNAs billing with their enrolled individual rendering NPI must not use modifiers listed.
Anesthesia

*Traditional and Care Select Members*

- Providers bill postoperative epidural catheter pain management using code 01996
- The IHCP does not separately reimburse this code on the same day the epidural is placed
  - However, the code is reimbursed for subsequent days when an epidural is managed
Injections
*Traditional and Care Select Members*

- The IHCP reimburses for physician office injectable drugs using Healthcare Common Procedure Coding System (HCPCS) J codes and CPT immunization codes
- Claims will be priced based on the Fee Schedule
- The IHCP reviews pricing for a physician office-administered drug each quarter
- To price appropriately, HCPCS J Codes must be submitted with the appropriate National Drug Code (NDC), name, strength, and quantity
Injections

*Traditional and Care Select Members*

- The *IHCP Provider Manual* contains lists of J codes that require an NDC
  - *Chapter 8, Section 4*
- For paper *CMS-1500* claim forms, report NDC information in the shaded area of field 24
- The NDC is not used for provider reimbursement
Diabetes Self-Care Training Services

*Traditional and Care Select Members*

- Diabetes self-care training is intended to enable the patient or enhance the patient’s ability to properly manage a diabetic condition, thereby optimizing the therapeutic regimen.
Diabetes Self-Care Training Services

*Traditional and Care Select Members*

- The IHCP limits coverage to eight units or a total of four hours per member, per rolling calendar year; providers can request prior authorization for additional units
- The following are examples of diabetes self-care management training activities:
  - Accessing community healthcare systems and resources
  - Behavior changes, strategies, and risk-factor reduction
  - Blood glucose self-monitoring
  - Instruction regarding the diabetic disease state, nutrition, exercise, and activity
  - Insulin injection
  - Foot, skin, and dental care
  - Medication counseling
  - Preconception care, pregnancy, and gestational diabetes
Diabetes Self-Care Training Services

*Traditional and Care Select Members*

- Providers must bill using one of the following HCPCS procedure codes:
  - G0108 – *Diabetes outpatient self-management training services, individual per 30 minutes*
  - G0109 – *Diabetes self-management training service, group session (2 or more), 30 minutes*
- Providers should not round up to the next unit; instead, providers should accumulate billable time equivalent to whole units and then bill
- Limit service to eight units per member, or the equivalent of four hours, per rolling calendar year, applicable under any of the following circumstances:
  - Receipt of a diagnosis of diabetes
  - Receipt of a diagnosis that represents a significant change in the member’s symptoms or condition
  - Re-education or refresher training
Surgical Services

*Traditional and Care Select Members*

- When two or more covered surgeries are performed during the same operative session, multiple surgery reductions apply to the procedure, based on the following adjustments:
  - 100% of the global fee for the most expensive procedure
  - 50% of the global fee for the second most expensive procedure
  - 25% of the global fee for the remaining procedures
- All surgeries performed on the same day, by the same rendering physician, must be billed on the same claim form; otherwise, the claim will be denied and the original claim may be adjusted.
Surgical Services

Traditional and Care Select Members

Cosurgeons:
- Cosurgeons must append modifier 62 to the surgical services
- Modifier 62 cuts the reimbursement rate to 62.5% of the rate on file

Bilateral Procedures:
- To indicate a bilateral procedure, providers bill with one unit in field 24G, using modifier 50
- Use of this modifier ensures that the procedure is priced at the lower of the billed charges or 150% of the rate on file

Note: If the CPT code specifies the procedure as bilateral, then the provider must not use modifier 50
Obstetric services

*Traditional and Care Select Members*

- The IHCP covers the following 14 antepartum visits:
  - Three visits in trimester one
  - Three visits in trimester two
  - Eight visits in trimester three

- Providers use the following codes to bill for visits:
  - First visit – Evaluation and management (E/M) – 99201-99205
  - Visits one through six – 59425
  - Seventh and subsequent visits – 59426

- Providers use the following modifiers with procedure codes:
  - U1 for trimester one – Zero through 14 weeks
  - U2 for trimester two – 14 weeks, one day through 28 weeks
  - U3 for trimester three – 28 weeks, one day through delivery
Obstetric Services

*Traditional and Care Select Members*

- For pregnancy-related claims, indicate the last menstrual period (LMP) in MM/DD/YY format in field 14
  - The IHCP will deny claims for pregnancy-related services if there is no LMP
- Indicate a pregnancy-related diagnosis code as the primary diagnosis when billing for pregnancy-related services
Obstetric Services

Traditional and Care Select Members

• Use normal low-risk pregnancy diagnosis codes:
  - V22.0
  - V22.1

• Use high-risk pregnancy codes:
  - V60.0 through V62.9

For additional information, see the IHCP Provider Manual, Chapter 8, Section 4
Therapy Services

Traditional and Care Select Members

- Written evidence of physician involvement and personal patient evaluation to document acute medical needs is required
- A physician must order the therapy
- A qualified therapist or qualified assistant under the direct supervision of the therapist, as appropriate, must provide the therapy
- The IHCP does not cover therapy rendered for diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities or developmental activities that can be conducted by nonmedical personnel
- The IHCP covers therapy for rehabilitative services for a member no longer than two years from the initiation of the therapy unless a significant change in medical condition requires longer therapy
Therapy Services

*Traditional and Care Select Members*

- Maintenance therapy is not covered
- When a member is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. The IHCP does not separately reimburse for ongoing evaluations.
- One hour of billed therapy must include a minimum of 45 minutes of direct patient care, with the balance of the hour spent in related patient services.
- The IHCP does not approve therapy services for more than one hour per day, per type of therapy.
The IHCP requires prior review and authorization for all therapy services with the following exceptions:

- Initial evaluations
- Emergency respiratory therapy
- Any combination of therapy ordered in writing before a member’s release or discharge from inpatient hospital care, which may continue for a period not to exceed 30 units, sessions, or visits in 30 calendar days
- Deductible and copay for services covered by Medicare Part B
- Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators
- Therapy services provided by an NF or large private or small ICF/IID, included in the facility’s per diem rate
Sterilization and Partial Sterilization

*Traditional and Care Select Members*

- A sterilization form is not necessary when a patient is rendered sterile as a result of an illness or injury
  - Providers must note partial sterilization with an attachment to the claim indicating “Partial Sterilization” and no consent required

- Partial sterilization can also be submitted on the electronic 837P transaction when “Partial Sterilization” is indicated in the claim notes
Sterilization and Partial Sterilization

*Traditional and Care Select Members*

- Providers must allow at least 30 days, but not more than 180 days, to pass between the date when the member gives the informed consent, and the date when the provider performs the sterilization procedure.

- Members who have retroactive eligibility or who failed to inform the provider of IHCP eligibility are still required to have a signed consent form, in order for the IHCP to reimburse the procedure.
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

☐ CONSENT TO STERILIZATION ☐

I have asked for and received information about sterilization from ___________________________. When I first asked ___________________________ for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father additional children.

☐ STATEMENT OF PERSON OBTAINING CONSENT ☐

Before ___________________________ , I explained to him/her the nature of sterilization operation ___________________________. The fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is ___________________________.
Family Planning Program  
*Traditional and Care Select Members*

- The Indiana Health Coverage Programs (IHCP) announced implementation of the Family Planning Eligibility Program effective January 1, 2013
- Family planning coverage is for services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy
- Members eligible under the Family Planning Aid Category will receive services through the Traditional Medicaid program within the fee-for-service delivery system
- Please see *IHCP Provider Manual, Chapter 8, Section 7*, for additional information regarding the covered services
Substitute Physicians
*Traditional and Care Select Members*

- A substitute physician is a physician who is asked by the regular physician to see a member in a reciprocal agreement when the regular physician is unable to see the member
- The substitute arrangement does not apply to physicians in the same medical group
- The substitute arrangement should not exceed 14 days
- The regular physician and substitute must both be enrolled in the IHCP
- In field 24 D of the *CMS-1500* claim form, use modifier Q5 to indicate the substitute physician provided the service
Locum Tenens Physicians

*Traditional and Care Select Members*

- Providers can create a *locum tenens* arrangement when the regular physician must leave his or her practice due to illness, vacation, or a medical education opportunity and does not want to leave his or her patients without service during this period.
- The *locum tenens* physician cannot be a member of the group in which the regular physician is a member.
- The *locum tenens* physician usually has no practice of his or her own and moves from area to area as needed.
- The *locum tenens* physician must meet all the requirements for practice in Indiana, as well as all the hospital or other institutional credentialing requirements, before providing services to IHCP members.
Locum Tenens Physicians

*Traditional and Care Select Members*

- The practitioner providing *locum tenens* services is not required to be an IHCP provider.
- The regular physician’s office must maintain documentation of the *locum tenens* arrangement, including what services were rendered and when they were provided.
- The regular physician’s office personnel submit claims for the *locum tenens* services using the regular physician’s NPI and modifier Q6 in form field 24D of the *CMS-1500* claim form.
- *Locum tenens* arrangements should not exceed 90 consecutive days. If the physician is away from his or her practice for more than 90 days, a new *locum tenens* would be necessary. If a *locum tenens* provider remains in the same practice for more than 90 days, he or she must enroll as an IHCP provider.
Helpful Tools
Helpful Tools

Avenues of resolution

• IHCP website at indianamedicaid.com
• IHCP Provider Manual, Chapter 8, Section 4
• Customer Assistance
  – 1-800-577-1278
• Written Correspondence
  – HP Provider Written Correspondence
    P. O. Box 7263
    Indianapolis, IN 46207-7263
• Provider Field Consultants
Q&A