Agenda

- Objectives
- CMS-1500 Claim Form
- Billing Guidelines
- NPI – Reporting
- Crossover Claims
- Risk-Based Managed Care
- Consent Form
- Sterilization and Partial Sterilization
- Prior Authorization Code Sets
- Fee Schedule
- Helpful Tools
- Questions
Objectives

• Following this session, providers will be able to:
  – Identify their provider classification
  – Understand how to report the NPI to EDS
  – Bill claims correctly for various specialties
  – Submit crossover claims successfully
  – Locate the IHCP fee schedule and provider code sets
  – Report NDC information for physician-administered drugs
**CMS-1500 Claim Form**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>17a</td>
<td>Enter qualifier ZZ and referring provider taxonomy number (if applicable) or qualifier 1D and referring provider or PMP (atypical providers) LPI.</td>
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<tr>
<td>17b</td>
<td>NPI of the referring provider.</td>
</tr>
<tr>
<td>24I and J</td>
<td>Qualifier ZZ and rendering provider taxonomy or 1D and rendering provider LPI for atypical providers.</td>
</tr>
<tr>
<td>24J</td>
<td>Rendering provider NPI</td>
</tr>
<tr>
<td>33</td>
<td>Billing provider service location – must include ZIP Code</td>
</tr>
<tr>
<td>33a</td>
<td>NPI for billing provider and 33b: Qualifier ZZ and billing provider taxonomy or qualifier 1D and billing provider LPI.</td>
</tr>
</tbody>
</table>
Billing Guidelines
Provider Classifications

- Billing Provider – Provider classification assigned to a billing entity or solo practitioner at a service location
- Group Provider – The classification given to a corporation or other business structure that has rendering providers linked who are the performers of the services provided
- Rendering Provider – A provider who performs the services for a group or clinic and is linked to the group or clinic
- Dual – A billing provider performing services as a sole proprietor at an assigned service location who is also a rendering provider working for a group
Billing Guidelines

• All enrolled providers are assigned a provider number, known as a legacy provider identifier (LPI)

• Billing and Group provider LPIS end with an alpha character that identifies the service location where services are furnished

• Rendering provider LPIS do not end with an alpha character
  – Rendering providers do not have service location alpha characters
  – They are linked to one or more groups at a specified service location(s)
  – The group bills for the rendering provider’s services
NPI - Reporting

Compliance date: To be determined

- The following functions cannot be performed if the NPI is not obtained and reported to the Indiana Health Coverage Programs (IHCP):
  - Eligibility inquiry
  - Claim submission
  - Claim inquiry
  - Check inquiry
  - Prior authorization submission and inquiry

- Access the NPI application online at: https://nppes.cms.hhs.gov/NPPES/Welcome.do
NPI - Reporting

- Providers should report their NPI to the IHCP using the NPI Web Reporting Tool located at: www.indianamedicaid.com.
- From the tool, complete the following fields:
  - Enter NPI
  - Select Taxonomy Codes
  - Submit Changes for this Provider
  - Report Rendering Providers
Crossover Claims
Processing Electronic Claims

• The Coordination of Benefits Contractor (COBC) crosses over HIPAA-compliant Medicare claims to the IHCP
  – The Centers for Medicare and Medicaid Services (CMS) selected Group Health, Inc. (GHI) to be the COBC
• When Medicare denied claims cross over to the IHCP, IndianaAIM adjudicates these with a denied status
• The IHCP created new edits for these claims. The edits are 0592 and 0593 – *Medicare denied details*
Crossover Claims
Processing Paper Claims

• Allow 60 days for claims to automatically cross over to the Indiana Health Coverage Programs (IHCP)
• Bill denied charges to the IHCP and include the Medicare Remittance Notice (MRN)
• Complete Field 22 as follows:
  - Left side = Co-insurance, deductible, and psychiatric reduction
  - Right side = Medicare payment
• Include the commercial payment amount in Field 29 (not used for traditional Medicare)
Billing Guidelines

Waiver

Once Eligibility Requirements Are Met:

• A case manager, along with the client and/or client’s representative, as well as other service providers, develop a Plan of Care (POC), which is reviewed by the state

• The Notice of Action (NOA) lists the approved and denied services for which the client may receive, along with the approved date span, units, and charge per unit

• Information from the NOA is sent to EDS for placement on the member’s Prior Authorization record for appropriate claims payment

• Claims pay only if PA dollars, units, and services are available for the dates of service submitted on the claim
Billing Guidelines
Waiver

- Notice of Action
  - Lists the approved service provider
  - Lists the approved service codes
  - Gives the approved units and dollar amounts

- CMS-1500 claim form
  - Use service code approved on the NOA
  - Include all modifiers listed with the service code

- Refer to the HCBS Waiver Program Provider Manual for information regarding
  - Service Definitions
  - Allowable Services
  - Service Standards
  - Documentation Standards
Billing Guidelines
Waiver

- Waiver providers use the CMS-1500 claim form when submitting paper claims for services
- The NPI is not needed for waiver providers who do not perform healthcare services
- Waiver providers may submit claims using their Legacy Provider Identifier (LPI) as they have in the past
- Waiver providers do not report or use a taxonomy code

**Note:** Targeted case managers who provide traditional Medicaid services for determining the waiver level of care should report and use their NPI
 Billing Guidelines

Vision

• 1 routine vision care exam and refraction for members 18 years or younger per rolling 12-month period
• 1 routine vision care exam and refraction every two years for members 19 years and older
• May only bill 1 unit, per member, per day for procedures
Billing Guidelines
Vision

- Providers must use the appropriate Current Procedural Terminology (CPT®) codes or Health Care Common Procedure Coding System (HCPCS) codes when submitting claims for vision services to the IHCP.
- Optometrists and opticians are subject to a vision code set.
- Code sets by specialty:
  - Optician – Specialty 190
  - Optometrist – Specialty 180
- For additional information on provider code sets, visit the IHCP Web site at www.indianamedicaid.com
- Members may self-refer for vision services. When a member is enrolled in an MCO, the provider must submit claims to the MCO for payment.
Billing Guidelines
Vision - Frames

- The IHCP provides reimbursement for frames, including, but not limited to, plastic or metal.
- The IHCP does not cover any portion of a deluxe or fancy frame purchase, except when medically necessary.
- If a member chooses to upgrade to a fancy frame, the entire frame is considered non-covered and the provider may bill the member as long as the member receives proper advance notice and signs to indicate that he or she understands the policy.
Billing Guidelines
Vision - Lenses

- If a member chooses to upgrade to progressive lenses, transitional lenses, anti-reflective coating, or tint numbers other than 1 and 2, the provider may bill the basic lens V code to the IHCP.

- The provider may bill the member for the upgrade portion, only if the member received appropriate advance notification of non-coverage.

- The IHCP only reimburses for polycarbonate lenses when deemed medically necessary.
Billing Guidelines
Replacement – Eye Glasses

• Replacement of eyeglasses beyond the indicated criteria must be medically necessary and clearly documented in the patient’s medical record.

• Replacement eyeglasses represent the beginning of a new limitation period.

• Modifiers:
  – RP – Replacement eyeglasses due to loss or theft
  – SC – Prescription change for lens or frames
Billing Guidelines

Anesthesia

Effective October 16, 2003, and after:

• Use CPT codes 00100-01999 (refer to IHCP provider bulletin BT200353 and IHCP banner page BR200350 for more information)

• Bill the actual time in minutes and include it in Field 24G

• 1 unit = 15 minutes

• Additional units are allowed based on a patient’s age when billing for emergency services (bill using procedure code 99140)
Billing Guidelines

Anesthesia

• Anesthesiologists billing the following procedure codes bill using the AA modifier:
  – 36555
  – 36220
  – 36625
  – 93503
  – 99116
  – 99183
  – 99185

• Bill these procedure codes in units (see IHCP provider bulletin BT200353 for more information)
Billing Guidelines
Anesthesia

- Providers bill post-operative pain management using code 01996.
- The IHCP does not separately reimburse this code on the same day the epidural is placed; however, it is reimbursed for subsequent days when an epidural is managed.
Billing Guidelines
Chiropractic Services

• Services are limited to 50 chiropractic services per member, per rolling 12-month period.
• The IHCP reimburses for no more than five office visits within the 50 visits.
Billing Guidelines
Chiropractic Services

• The following are covered codes for office visits:
  – 99201, 99202, 99203, 99211, 99212, 99213

• The following are covered codes for manipulative treatment:
  – 98940-98943

• Package C members are allowed five office visits and 14 therapeutic physical medicine treatments per member, per calendar year.

• Package B reimbursement is available for medically necessary pregnancy-related services. The following are appropriate chiropractic diagnosis codes for package B members:
  – 646.93, 648.73, 648.93
Billing Guidelines
Injections

- The IHCP reimburses for physician office injectable drugs using HCPCS J codes and CPT immunization codes.
- Pricing includes the current average wholesale price plus a $2.90 administration fee.
- The IHCP reviews pricing for a physician office administered drug each quarter.
- To price appropriately, HCPCS code J3490 must be submitted with the appropriate National Drug Code (NDC), name, strength, and quantity.
Billing Guidelines
Injections and NDC Codes

• Provider bulletin BT200713 contains a listing of J codes that require a National Drug Code (NDC)
  – Pertains to professional claims only
  – Must be reported in a 5:4:2 format
• Report NDC information in the shaded area of block 24 of the CMS-1500 claim form
• The NDC is not used for provider reimbursement

NOTE: Institutional providers will be required to utilize NDC codes for outpatient claims beginning January 1, 2008
Billing Guidelines
Vaccines for Children

• All Medicaid-eligible children younger than 19 years old are eligible to receive vaccines through the Vaccines for Children (VFC) program.
• An administration fee is included in the $8.00 VFC reimbursement.
• Providers are no longer required to separate stock.
• Providers may bill for private stock to the IHCP with the appropriate HCPCS and administration fee code.

For additional questions about the VFC program call: 317-233-7004 or 800-701-0704
Billing Guidelines
Mental Health – Mid-level Practitioners

- A Health Services Provider in Psychology (HSPP) or psychiatrist may be a supervising practitioner for a mid-level practitioner
- Mid-level practitioners use the following modifiers:
  - AH – Services provided by a clinical psychologist
  - AJ – Services provided by a clinical social worker
  - HE in conjunction with SA – Services provided by a nurse practitioner (NP) or clinical nurse specialists (CNCs)
  - HE – Services provided by any mid-level practitioner as addressed in the 404 IAC 5-25
  - HW – Medicaid Rehabilitation Option (MRO) services
  - SA – NP/CNS in a non-mental health arena
Billing Guidelines
Mental Health Limitations

• The following HCPCS codes are limited to 20 visits per member, per provider, per rolling 12-month period
  – 90801-90802
  – 90804-90815
  – 90845-90857
  – 96151-96153

• The IHCP does not cover the following services:
  – Biofeedback
  – Broken or missed appointments
  – Day care
  – Hypnosis
  – Partial hospitalization, except as set in 405 IAC 5-21
Risk-Based Managed Care

- Effective January 1, 2007, outpatient mental health services are carved-in to the RBMC delivery system

- **Services provided to RBMC members by the following specialty types are the responsibility of the MCOs, effective January 1, 2007:**
  - Freestanding Psychiatric Hospital
  - Outpatient Mental Health Clinic
  - Community Mental Health Center
  - Psychologist
  - Certified Psychologist
  - HSPP
  - Certified Clinical Social Worker
  - Psychiatric Nurse
  - Psychiatrist
Risk-Based Managed Care

- Services that are the MCO’s responsibility:
  - Office visits with a mental health diagnosis
  - Services ordered by a provider enrolled in a mental health specialty, but provided by a non-mental health specialty (such as a laboratory and radiology)
  - Mental health services provided in an acute care hospital
  - Inpatient stays in an acute care hospital or freestanding psychiatric facility for treatment of substance abuse or chemical dependency
Risk-Based Managed Care

• MCOs
  – Anthem
    www.anthem.com
  – Managed Health Services (MHS)
    www.managedhealthservices.com
  – MDwise
    www.mdwise.org

• Behavioral Health Organizations (BHO)
  – Magellan (Anthem)
    www.magellanhealth.com
  – Cenpatico (MHS)
    www.cenpatico.com
  – CompCare (MDwise)
    www.compcare.com
Billing Guidelines
Obstetric Services

• 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
Billing Guidelines
Pregnancy Diagnosis Codes

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

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

For additional information, refer to the IHCP Provider Manual, Chapter 8.
Billing Guidelines
Pregnancy-Related Claims

• For pregnancy-related claims, indicate the last menstrual period (LMP) in MM/DD/YY format in Field 14. The IHCP does not process 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.
Billing Guidelines
Multiple Surgery Procedures

• 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 percent of the global fee for the most expensive procedure
  – 50 percent of the global fee for the second most expensive procedure
  – 25 percent 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 may be denied and the original claim may be adjusted.
Billing Guidelines
Surgical Services

Cosurgeons:

• Cosurgeons must append modifier 62 to the surgical services.
• Modifier 62 cuts the reimbursement rate to 62.5 percent 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 150 percent of the billed charges or the rate on file.

Note: If the CPT code specifies the procedure as bilateral, then the provider must not use modifier 50.
Billing Guidelines

Therapy Services

- Per 405 IAC 5-22-6, prior review and authorization by the office is required for all therapy services with the following exceptions:
  - Initial evaluations
  - Emergency respiratory therapy
  - Any combination of therapy ordered in writing prior to a member’s release or discharge from inpatient care, which may continue for a period not to exceed 30 units, sessions, or visits in 30 calendar days
  - Deductible and co-payment 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 a nursing facility or large private ICF/MR, included in the facility’s per diem
  - Physical therapy, occupational therapy, and respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in Sections 8, 10, and 11 of this rule
Billing Guidelines
Therapy Services – Physical Therapist Assistant’s Rule Change

- Indiana Administrative Code (IAC) 405 IAC 1-11.5-2 was amended to allow for the reimbursement of services provided by certified physical therapist assistants (PTAs), whether independent or hospital-based.

- The PTA is precluded from performing and interpreting tests, conducting initial or subsequent assessments, and developing treatment plans. Under direct supervision, a PTA is still required to consult with the supervising physical therapist daily to review treatment.

- The consultation can be either face-to-face or by telephone.
Billing Guidelines
Therapy Services – Physical Therapist Assistant’s Rule Change

• PTAs are eligible for reimbursement using the HM – *Less than a bachelor’s degree*, modifier

• The IHCP reimburses services rendered by PTA at 75 percent of the reimbursement level for a physical therapist

See IHCP provider bulletin BT200611 for additional information
Billing Guidelines
Podiatric Services – Routine Foot Care

• Routine foot care is only covered if a member has been seen by a medical doctor or doctor of osteopathy for treatment or evaluation of a systemic disease during the six-month period prior to rendering routine foot care.

• A maximum of six routine foot care services is covered per rolling 12-month period when the member has one of the following:
  – Systemic disease of sufficient severity that a treatment of the disease may pose a hazard when performed by a non-professional.
  – Systemic conditions that results in severe circulatory embarrassment or has had areas of desensitization in the legs or feet.
Billing Guidelines
Podiatric Services – Routine Foot Care

• ICD-9-CM diagnosis codes that represent systemic conditions that justify coverage for routine foot care:
  – Diabetes mellitus: ICD-9-CM codes 250.00-250.91
  – Arteriosclerotic vascular disease of lower extremities: ICD-9-CM codes 440.20-440.29
  – Thromboangitis obliterans: ICD-9-CM code 443.1
  – Post-phlebitis syndrome: ICD-9-CM code 459.1
  – Peripheral neuropathies of the feet: ICD-9-CM codes 357.1-357.7

• Routine foot care is not a covered service for Package C members
Billing Guidelines
Podiatric Services – Routine Foot Care

- Reimbursement is limited to one office visit using procedure code 99211, 99212, and 99213 per member, per 12 months, without obtaining prior authorization.
- New patient office visits, using procedure codes 99201, 99202, and 99203 are reimbursable at one per member, per provider, within the last three years as defined by the CPT guidelines.
- A visit can be billed separately only on the initial visit
- For subsequent visits, reimbursement for the visit is included in the procedure performed on that date and not billed separately
  - Exception: If a second, significant problem is addressed on a subsequent visit, the visit code may be reported with the 25 modifier.
Billing Guidelines
Diabetes Self-Care Management

• The IHCP defines self-care training as services provided in accordance with the terms and provisions of IC 27-8-14.5(6).

• Such services are intended to enable the member or enhance the member’s ability to properly manage a diabetic condition.

• Providers may bill services on a paper CMS-1500 claim form or using the 837P electronic transaction.

• G0108 or G0109 – one unit is equal to 30 minutes of service.

• There is a limit of eight units per member, or the equivalent of four hours, per rolling 12-month period.
Billing Guidelines
Evaluation and Management Codes

Reimbursement is available for office visits to a maximum of 50 per year, per IHCP member, without 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.

<table>
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<tr>
<th>Procedure Codes</th>
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<tr>
<td>99201-99215</td>
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<tr>
<td>99241-99245</td>
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<td>99271-99275</td>
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<tr>
<td>99381-99397</td>
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<td>99401-99429</td>
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Billing Guidelines
Evaluation and Management Codes

• Professional services rendered during the course of a hospital confinement must be submitted on the paper CMS-1500 claim form or using the electronic 837P transaction.

• The IHCP makes reimbursement in accordance with the appropriate professional fee schedule.

• The inpatient diagnosis-related grouping (DRG) reimbursement methodology does not provide payment for physician fees, including the hospital-based physician fee.

• New patient office visits are limited to one visit per member, per provider – once every three years.
CONSENT FORM

STATEMENT OF PERSON OBTAINING CONSENT

Before ______________________ signed the consent form, I explained to him/her the purpose of the sterilization operation known as ______________________ 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 at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

PHYSICIAN’S STATEMENT

Shortly before ______________________ performed the sterilization operation upon ______________________ I explained to him/her the purpose of the sterilization operation known as ______________________ 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
Sterilization and Partial Sterilization

Partial Sterilization

- 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 Procedure
Essure

- Can be performed in the office, as an outpatient or an ambulatory surgical center (ASC)
- Device billed separately on CMS-1500 form using sterilization HCPCS code A9900- *Miscellaneous supply, accessory, and/or service component of another HCPCS code*
- Use primary diagnosis code of ICD-9-CM V25.2 Sterilization
- Submit cost invoice with claim
- Submit a valid, signed Sterilization Consent form
- Print **Essure Sterilization** on the claim form or on the invoice

Refer to BR200734 for more information
Prior Authorization

- **Through October 31, 2007**, mail PA requests to:
  - Health Care Excel Prior Authorization Department
  - P. O. Box 531520
  - Indianapolis, IN 46253-1520

- Obtain emergency PA by calling the HCE Prior Authorization Department at (317)347-4511 or (800) 457-4518.

- **On and after November 1, 2007**, mail PA requests to:
  - ADVANTAGE Health Plan-FFS
  - P.O. Box 40789
  - Indianapolis, Indiana 46240

- Or call 1-800-269-5720

- For RBMC members, contact the appropriate MCO
Code Sets

The following provider types have specific code sets:

- Chiropractic – July 1, 2003
- Durable Medical Equipment – August 1, 2006
- Hearing Services – October 1, 2004
- HIV Care Coordination – October 1, 2004
- Home Medical Equipment – August 1, 2006
- Optician – October 1, 2004
- Optometrist – October 1, 2004
- Transportation – July 1, 2004
- Vision – October 1, 2004
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<tr>
<td>S3</td>
<td>SalyersPA, 10/2/2007</td>
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Fee Schedule

The IHCP Fee Schedule is available on the IHCP Web site and provides the following information:

- Pricing for procedure codes
- PA requirements for individual procedure codes
- Lists of non-covered codes
Modifications to Duplicate Logic

- IndianaAIM now reads all five digits of the procedure code and all modifiers.
- Applicable to claims and replacement claims received on or after September 27, 2007.
- Applicable to the following claim types:
  - Medical
  - Medical Crossover Part B
  - Outpatient
  - Outpatient Crossover C
  - Home Health

- Effective August 1, 2007:
  - Crossover claims billed on a CMS-1500 claim form no longer deny with edits 5007 (exact duplicate, header), or 5008 (suspect duplicate, header)
  - These claims now emulate the possible, and exact duplicate logic applied to medical claims, which apply the 5000 (possible duplicate), and 5001 (exact duplicate) edits.
Modifications to Duplicate Logic

Example 1:

10/25/07   73560 LT
10/25/07   73560 RT

Example 2:

10/26/07   H0044 HW HQ AH
10/26/07   H0044 HW HQ HE

The second detail line will no longer deny as a duplicate to the first detail line
Helpful Tools

Avenues of Resolution

• IHCP Web site at www.indianamedicaid.com
• IHCP Provider Manual (Web, CD-ROM, or paper)
• HCBS Waiver Provider Manual (Web)
• Customer Assistance
  – 1-800-577-1278, or
  – (317) 655-3240 in the Indianapolis local area
• Written Correspondence
  – P.O. Box 7263
  Indianapolis, IN 46207-7263
• Provider Relations Field Consultant
Questions