Agenda

- Objectives
- Provider Search
- National Provider Identifier
- New Dental Claim Form
- Dental Billing and Rendering Provider Information
- Spend-down
- Managed Care
- Dental Cap
- Third Party Liability
- CDT-4 Codes
- Fee Schedule
- Dental Policy
- Web interChange
- Claim Submission
- Top Denials
- Helpful Tools
- Questions
Objectives

• At the end of the presentation, providers will understand:
  – Billing on the new ADA Claim form
  – The difference between group, billing, and rendering providers
  – How to bill claims that are not Medicaid primary
  – Changes to dental policy
  – How to best utilize the Web interChange
  – Claim denials
Provider Search

The IHCP includes a **Provider Search** feature on the IHCP Web site under Provider Services

- Search for provider types and specialties
- Search by location, institution, city, county, or ZIP Code
- Retrieve information and print. Providers may give this information to the member

**Note:** *The member should contact the provider to ensure he or she is accepting new Medicaid patients*
The National Provider Identifier (NPI) is a unique health identifier for all healthcare providers who submit health information in a HIPAA standard format.

Use of the NPI reduces the need for providers to maintain multiple identification numbers.

The National Plan and Provider Enumeration System (NPPES) issues the NPI. Providers may request their NPI online or via paper by visiting [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do).

Obtain more information on the NPI page at [www.indianamedicaid.com](http://www.indianamedicaid.com).
New Dental Claim Form ADA 2006

- BT200705 details the requirements of the ADA 2006
  - Reporting billing and rendering provider information
  - Reporting NPI of the billing and rendering providers
- Either the old or the new claim form may be used until further notice
New Dental Claim Form ADA 2006
Dental Billing and Rendering Provider Information

• Report billing and rendering provider information on dental claim form:
  – Billing provider NPI Field 49
  – Billing provider LPI Field 50
  – Rendering provider NPI Field 54
  – Rendering provider LPI Field 58

• Rendering providers must be associated with the billing provider’s group

• Web interChange users must report rendering provider information on the detail line

• The RA identifies the rendering provider information

• Identify all NPI edits prior to Phase III to assure no interruption in payment

• Phase III of NPI and ADA 2006 form is to be determined
Spend-down

• Effective January 1, 2006, members do not need 8A forms, and the caseworker is no longer directly involved

• Members are eligible at the beginning of the month

• The spend-down amount is deducted from the first claim processed by the IndianaAIM system

• ARC 178 appears on the remittance advice when spend-down is credited on claims

• Providers may bill the member for the amount listed beside ARC 178

• Members are responsible to pay upon receipt of the Spend-down Summary Notice
Managed Care in Indiana

• Dental services are *carved-out* of the risk-based managed care (RBMC) delivery system

• Dental providers who bill Current Procedural Terminology (CPT®) codes must submit claims using the electronic 837P transaction or the paper CMS-1500 claim form
  – These claims must be submitted to the managed care organization (MCO) after obtaining authorization

• Members with Traditional Medicaid, *Medicaid Select/Care Select* including spend-down, and Level of Care, are not enrolled in a managed care organization (MCO)

• Providers must bill all dental services using Current Dental Terminology (CDT)-4 procedure codes using the electronic 837D transaction or the paper 2006 ADA claim form
Billing a Member if Dental Cap is Exhausted

- **Annual Dental Cap amount is $600.00**
- When the member exhausts the $600.00 annual cap, the provider can bill member the usual and customary fees
- **Example:**
  - On the date of service, $400.00 of the cap amount has been exhausted ($200.00 of the cap amount remains)
  - The provider renders services equal to reimbursement of $300.00
  - The provider can bill the member for $100.00

See the IHCP Provider Manual and IHCP Provider Bulletin BT200324
Third Party Liability Program
Cost Avoidance

• The primary responsibilities of the third party liability (TPL) program are the following:
  – Identify IHCP members who have third party resources
  – Ensure that those resources pay prior to the IHCP

• In Indiana, Victims Assistance, First Steps, Children’s Special Health Care Services, and Health Care for the Indigent are the only resources that do not need to be used prior to billing the IHCP
Third Party Liability Program
Billing Tips

• If a third party makes a payment, an Explanation of Benefits (EOB), Explanation of Payment (EOP), or remittance advice (RA) is not required

• Enter TPL paid amount on the claim in field 35

• If a member has another insurance, but the payment is $0, or the member is not eligible for benefits, the EOB, EOP, or RA is required. Include .00 on the claim

• Submit coordination of benefits (COB) information on the header and the detail when filing claims using Web interChange

• Always verify TPL information prior to providing services. The eligibility verification systems (EVS) identify active TPL for eligible members

• Providers may update TPL through Web interChange or by contacting the EDS TPL Unit
Third Party Liability Program
Blanket Denials

What is a *blanket denial*?

- When a healthcare service is not a covered benefit for the insured, the IHCP accepts an EOB from the other insurer showing that the service is not covered.

What must the *blanket denial* EOB include?

- Name of primary insurance carrier
- Information sufficient to identify the member
- Description of healthcare service
- Statement of non-coverage of the service

*Blanket denial* EOBs can be used until the end of the calendar year of the date of the EOB and must contain the same procedure code(s) that are billed on the claim.
Third Party Liability Program

90-Day Provision

• What is the 90-Day Provision?
• How to submit claims under the 90 Day Provision:
  – Indicate **90-Day Provision**
  – Include attachments to support previous attempts to file with the primary carrier
  – Web interChange users may insert a claim note to invoke the 90-Day Provision

*IHCP Provider Manual, Chapter 5,* contains billing instructions
Third Party Liability Program
Insurance Carrier Reimburses IHCP Member

• Contact the TPL and advise them that payment was made to the member in error

• If unable to recover payment from a member or TPL, the provider should submit the claim under the 90-Day Provision

• Have the member sign an assignment of benefits authorization form. This form states the member authorizes the insurance carrier to reimburse the provider directly
CDT-4 Codes

Effective January 1, 2007:

- Refer to the *IHCP Fee Schedule* or the *IHCP Provider Manual, Chapter 8, Section 4* to determine which CDT-4 codes are covered
- BT200630 and BR200718 list updates and changes to some dental codes
Fee Schedule

The IHCP Fee Schedule is available on the IHCP Web site at www.indianamedicaid.com

• Included on the fee schedule:
  - Pricing for procedure codes
  - Code descriptions
  - Code start and end date
  - Prior Authorization requirements for codes
  - Lists non-covered codes
Dental Policy
Evaluation Codes

• Use the following codes to bill for evaluations:
  
  – **D0120** – Periodic Oral Evaluation. **One** visit per member every **six months**.
  
  – **D0150** – Comprehensive Oral Evaluation – new or established patient or **D0160** Extensive Oral Exam.
    
    • Two visits per member, per year, per lifetime, per provider. The two unit limitation applies to any combination of these two codes billed per year, per member.
  
  – **D0140** – Emergency Oral Exam.
    
    • Enter the word *Emergency* in field 2 of the ADA 2006
Dental Policy
Fluoride

• For fluoride services rendered prior to 1/1/07:
  – **D1201** – Topical application of fluoride, including prophylaxis, ages 1-12. No longer covered as of date of service (DOS) 12/31/06
  – **D1205** – Topical application of fluoride, including prophylaxis, ages 13-20. No longer covered for as of DOS 12/31/06

• For fluoride services rendered on and after 1/1/07:
  – **D1203** – Topical application of fluoride, excluding prophylaxis, ages 1-12
  – **D1204** – Topical application of fluoride, excluding prophylaxis, ages 13-20
Dental Policy
Prophylaxis

• Use the following codes to bill for prophylaxis:
  – **D1120** – Prophylaxis for child – ages 1-12
  – **D1110** – Prophylaxis for adult – ages 13 and older

• The IHCP covers **two cleanings** per year for members **20 years old and younger**, and **one cleaning** per year for members **21 years and older**

• If the member is **institutionalized**, he or she is eligible for **two** cleanings per year
Dental Policy
Periodontal Scaling and Root Planing

• Claims submitted for procedure code D4341 after March 1, 2003, must have **required documentation** to support the procedure

• IHCP provider bulletin *BT200311* includes information about required documentation

  **Note: Do not include quadrants on the detail lines**

• D4341 is limited to **four units per lifetime**, unless institutionalized. Quadrant limitation verification is available on the EVS and is noted only after the fourth quadrant is paid

  – Providers may also send an inquiry to Written Correspondence requesting paid claim history.

See IHCP provider bulletin *BT200364* for details on filing an electronic claim with paper attachment(s)
Dental Policy

Sealants

- The IHCP only covers procedure code D1351 – Sealants, for permanent molars and premolars
- Reimbursement is limited to members younger than 21 years old, one sealant per tooth, per lifetime
- EVS provides the necessary information to verify sealed teeth
Dental Policy
Multiple Restoration Reimbursement

• The IHCP reimburses for only one restoration code per tooth using the same material when performed on the same date by the same dentist for the same member.

• When a dentist performs multiple restorations on the same tooth, on the same day, and uses different materials on the same surface (without a second surface), the IHCP reimburses for a single surface restoration for each material. The IHCP reviews these claims for medical necessity.

See IHCP provider bulletin BT200141 for more information.
Dental Policy
Extractsions

• The IHCP reimburses 100 percent of the maximum allowed amount or the billed amount, whichever is less, for the initial extraction.

• For multiple extractions within the same quadrant on the same date of service, the IHCP reimburses 90 percent of the maximum allowed amount for procedure code D7140 or the billed amount, whichever is less.

• Bill only one tooth number per detail line.

See IHCP provider bulletin BT200364 for more information.
Dental Policy
Billing for Dentures

- The delivery date is the date of service.
- Providers may charge the member for dentures if the member is ineligible upon delivery. A waiver is not required.
- Providers must verify member eligibility prior to rendering services and must explain to the member that if his or her eligibility is terminated, the member is responsible for the cost of the dentures.
Dental Policy
PA Requirements for Dentures

• Dentures, partials, relines, and repairs require prior authorization (PA) and apply to the dental cap
• Denture replacement requires PA
• Requests for relines or repairs may be approved if they will extend the useful life of a prosthesis
• Members 20 years old and younger do not require PA for dentures

See BT200707 McCarty v. Roob for additional information
Dental Policy
Orthodontia

- Effective August 5, 2002, **all orthodontic procedures** require PA.
- **The IHCP only approves orthodontic procedures** in cases of craniofacial deformity or cleft palate.
- The patient must be diagnosed by a member of the American Cleft Palate – Craniofacial Association. The member’s licensed practitioner must minimally accept routine craniofacial patients for orthodontic services such as cleft lip and palate.
Dental Policy
Orthodontia

- The diagnosis must include descriptive information of facial and soft tissue, skeletal, dental/occlusal, functionality, and applicable medical or other conditions
- The treatment plan must accompany the request for authorization. The plan must show the phase and length of treatment
- The IHCP authorizes PA on a case-by-case basis
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 11-1-07**, mail PA requests to:
  
  ADVANTAGE Health Plan-FFS
  P.O. Box 40789
  Indianapolis, Indiana 46240

• Or call 1-800-269-5720
Dental Policy
General Anesthesia

Effective June 1, 2003:

• **D9220** and **D9221** (General Anesthesia) is reimbursable. Per **405 IAC 5-14-15**, Medicaid reimbursement is available for general anesthesia.

• General anesthesia for members 21 years of age and older may only be provided in a hospital (inpatient or outpatient) or ambulatory surgical center and must include documentation of the following in the patient’s record to be eligible for reimbursement:
  - Specific reasons why such services are needed, including specific justification if such services are to be provided on an outpatient basis.
  - Documentation that the member cannot receive necessary dental services unless general anesthesia is administered.
    • Example: a member may be unable to cooperate with the dentist due to physical or mental disability.
Dental Policy
IV Sedation

• Bill **D9241** and **D9242** for intravenous conscious sedation and analgesia

• The IHCP reimburses these codes in conjunction with services provided for oral surgery procedures only

• Maintain **documentation** in the patient’s file to support the service provided
Dental Policy
Posting Payments and Refiling Claims

• Check all detail lines when posting IHCP payments to ensure all procedures are reimbursed
• Only resubmit denied details to avoid duplicate payments
• Send paper claims to:

  Dental Claims
  PO Box 7268
  Indianapolis, IN  46207-7271

• Resubmit using Web interChange
Web interChange
www.indianamedicaid.com

• Allows for claim submission directly to EDS
• Allows access to claim and member information
• Provides for secure data transmission
• Available 24 hours a day, seven days a week
• Free!
Web interChange
Functions

• Member eligibility verification
• Claim submission including voids and replacement and electronic attachments
• Claim status inquiry
• Check inquiry
• Provider profile inquiry, including access to enrollment documents
• Web Administrator
• PA submission and inquiry
Web interChange
Member Eligibility

• On the home page, click **Eligibility Inquiry**

• Enter provider ID, location code, and the member’s ID

• Verify a member’s IHCP eligibility for the date entered
  – Name and demographics
  – Spend-down, level of care (LOC), Medicare
  – TPL information
  – Managed care information
  – Restricted information
  – Amount of dental cap paid
  – Services benefit limitations (based on provider type and specialty)
Web interChange
Benefit Limitations

• Audit 6212 - Fluoride treatment limited to one every six months
  – D1201, D1203, D1204, D1205

• Audit 6221 - Periodontal root planing/scaling four times per two years, non-institutionalized members
  – D4341

• Audit 6033 - Prophylaxis limited to two per six months, institutionalized members
  – D1110, D1120

• Audit 6209 – Full mouth or panoramic x-rays limited to once every three years
  – D0210, D0330

• Audit 6210 - Prophylaxis limited to one treatment every six months
  – D1110, D1120, D1121
Web interChange

Benefit Limitations

- Audit 6211 – Periodic or limited oral evaluation, limit one every six months
  - D1110, D1120
- Audit 6222 - Periodontal root planing and/or scaling four times per two years, institutionalized members
  - D4341
- Audit 6223 - Periodontal root planing four per lifetime, 21 years or older, non-institutionalized members
  - D4341
- Audit 6235 - Prophylaxis non-institutionalized members 21 years or older, limit one per 12 months
  - D1110
  - D1351
• Audit 6236 - Dental services limited to $600 for 21 and over
  - D0120, D0140, D0145, D0150, D0160, D0170, D0210, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0274, D0290, D0310, D0320, D0321, D0322, D0330, D0340, D1110, D2110, D2120, D2130, D2131, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2380, D2381, D2382, D2385, D2386, D2387, D2388, D2391, D2392, D2393, D2394, D2910, D2920, D2930, D2931, D2940, D2951, D2970, D2980, D3110, D3120, D3220, D3230, D3240, D4210, D4211, D4240, D4241, D4261, D4355, D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226, D5510, D5520, D5610, D5620, D5630, D5640, D5650, D5660, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D9220, D9221, D9230, D9248, D9310, D9610, D9930

• Audit 6225 - One sealant per tooth per lifetime
  - D1351
Web interChange
Claim Submission

• Submit dental claims with as many as 50 details
• Add, copy, or delete details
• Rework denied claims
• Mail attachments separately
  – Claims that require attachments suspend for 45 days waiting for the attachments to arrive
• Claim notes to reduce paper attachments
  – 90-Day Provision
  – Supernumerary teeth
Claim Submission
Claim Notes for 90-Day Provision

Effective June 6, 2005:

• Use claim notes instead of a separate attachment when submitting claims for the 90-Day Provision using Web interChange

• Document in the claim note segment:
  – The phrase 90-Day Provision
  – The member’s RID number
  – Date of filing attempts
Claim Submission
Claim Notes for Supernumerary Tooth Extraction

Effective June 6, 2005:

• Use claim notes instead of a separate attachment when billing for supernumerary tooth extraction (D7999) via Web interChange.

• Use the following description to identify the tooth extracted along with the required criteria as described in BT200511
  – Child - Designate the tooth ID using the appropriate number followed by an A.
  – Adult – Designate the tooth ID by the appropriate tooth number followed by a 1.

• If submitting a paper claim, use a claim attachment. The attachment should indicate the type of extraction performed, erupted or impacted tooth. An impacted tooth must be documented as whether it is soft tissue, partially bony, or completely bony with any unusual complications listed.
Claim Submission
Coordination of Benefits

• COB information is **required** for TPL and crossover claims

• **Click Benefit Information** to open the COB window
  – Report the primary insurance information that applies to the entire claim

• **Click Detail Benefit Info** to open the detail COB window
  – Report the primary insurance information that applies to each detail line individually
  – Complete this window for **each** detail line on the claim

• Access a TPL help guide on the Web interChange help page
Web interChange
Claim Inquiry

- Inquire about previously submitted claims – even before they appear on an RA
- View the claim status within two hours of submitting the claim using the internal control number (ICN) that displayed when the claim was submitted
- Search by date range, member ID, or ICN
- When the claim displays, click on the ICN to retrieve the detailed information for the claim

Note: Built-in security features allow only the billing provider to view the claims it submits
Web interChange
Voids and Replacements

• Access the Claim Inquiry function to void or replace claims

• A *void* is the cancellation of an entire claim, whether same day, same week, or post financial

• A *replacement* is a change to an original claim, whether same day, same week, or post financial

See IHCP bulletin *BT200511* for more information.
Web interChange
Voids

• Submit void requests electronically using the 837D electronic transaction or Web interChange

• Submit void requests for a previously paid claim submitted either electronically or via paper

• A void cancels the original claim

• The original claim being voided cannot be in a denied status

• There is no filing limit for void requests
Web interChange
Replacements

- A replacement takes the place of the original claim
- When the IHCP receives a replacement claim, the replacement becomes a new claim (including attachments and claim notes)
Web interChange
Replacements

• A replacement claim can be submitted using the electronic 837D transaction or Web interChange
• A replacement also can be submitted on paper (also known as an adjustment)
• Check-related replacements must be submitted on paper
• There is a one-year filing limit for replacement requests
• If the date of service is over the one-year filing limit, utilize the Replace This Claim feature and click on the Attachments button to include proof of timely filing documentation
Web interChange
Check Inquiry

• Inquire about previously received payments
• Find a check or Electronic Funds Transfer (EFT) by searching within a date range or by searching for a specific check number
• When the basic check information displays, click on that line to see all of the paid claims associated with that check

Note: Built-in security features allow only the billing provider to view the checks that it has received
Web interChange
Provider Profile

- Allows IHCP providers to view profile information
- Includes the basic profile, service location information, and rendering provider information
Web interChange
Web Administrator

- This function allows one person within the provider group to determine which users have access to specific functions of Web interChange
- The Web Administrator can create, maintain, and delete user groups; reset passwords; and modify user information
- When a provider has a Web Administrator, each user’s assigned login ID and password is unique, and is not a provider number
Web interChange
Web Administrator

- Web interChange users who log on using a provider number but do not have a Web administrator:
  - Do not receive Web interChange updates
  - Cannot view their provider profile, or submit and inquire on PA requests using Web interChange
- New providers applying for an ID and password must set up a Web administrator
- Web administrator will be required for all providers using Web interChange
Web interChange
Prior Authorization Inquiry and Submission

• A requesting provider may inquire about all non-pharmacy prior authorization (PA) using the Web
  – The PA request may have been submitted on paper, by telephone or fax, or through the Web
  – The requesting provider and the named service provider may view a PA without the PA number
  – All other providers must have the PA number to view the PA

• This function allows providers to submit PA requests via the Web in a HIPAA-content compliant format

• Health Care Excel (HCE) processes all PA requests and sends decision letters until 10-31-07

• ADVANTAGE Health Plans will process all PA requests on and after 11-1-07 for traditional Medicaid

• Medicaid Select/Care Select are self referral
Top Denials

• 1108 – Billing NPI has no matching LPI
• 1128 – Rendering NPI has no matching LPI
• 2001 – Recipient number not on file
• 0238 – Recipient name missing
• 1010 – Rendering provider not a member of the group
• 5001 – Exact duplicate
• 2504 – Recipient covered by private insurance
• 4034 – Procedure code vs. age restriction
• 0513 – Recipient name and number disagree
• 2003 – Recipient ineligible on date of service
• 6000 – Manual pricing required
• 0262 – Tooth number invalid
Helpful Tools
Avenues of Resolution

• IHCP Web site at www.indianamedicaid.com

• *IHCP Provider Manual* (Web, CD-ROM, or paper)

• Customer Assistance
  – Local 1-317-655-3240
  – All others 1-800-577-1278

• Written Correspondence
  EDS Provider Written Correspondence
  P. O. Box 7263
  Indianapolis, IN 46207-7263

• Provider Field Consultant
Questions