Agenda

– Objectives

– Provider Classifications

– Web interChange

– Billing

– Prior Authorization

– Dental Services

– Dental Policy

– Claim Returns and Denials

– Helpful Tools

– Questions
Session Objectives

At the end of this session, providers will understand the following:

– Difference between group, billing, dual, and rendering providers

– Claim processing

– Dental services

– How to avoid claim denials
Define

Provider Classifications
Provider Classifications

How are you enrolled?

- **Billing Provider** – A practitioner or facility operating under one NPI number
  - The provider will use the same NPI for billing and rendering

- **Group Provider** – Any practice with one common NPI for billing
  - The group must have members linked to the business, and these members are identified as “rendering providers” and will have their own NPI

- **Dual Provider** – A provider that is both a billing and a rendering provider
  - Provider may use one NPI to bill and also as a rendering for a different group
Provider Classifications

How are you enrolled?

- **Rendering Provider** – A practitioner employed by a group provider; the rendering provider actually performs the service
  - The Indiana Health Coverage Programs (IHCP) makes payment to the group
  - Rendering providers must be associated with the billing provider’s group and linked to that group in the provider profile
  - The Remittance Advice (RA) identifies the rendering provider National Provider Identifier (NPI) on the detail line

- **Ordering, Prescribing and Referring Provider (OPR)**
  - The Affordable Care Act requires all ordering, prescribing and referring providers to be enrolled in the Indiana Health Coverage Programs (IHCP)
    - claims processing will monitor whether the OPR provider is enrolled
    - claims will deny if the OPR is not enrolled
    - OPR providers do not submit claims for payment
    - a directory of OPR providers will be maintained on indianamedicaid.com, Provider Search function
Web interChange

Functions

– Member eligibility verification

– Claim submission including voids and replacement and electronic attachments

– Claim status inquiry

– Check/RA inquiry

– Provider profile inquiry, including access to enrollment documents

– Web administrator

– PA submission and inquiry

– Available 24 hours a day, seven days a week

– Free!
Web interChange
Member eligibility

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

– Enter the member ID

– Enter the desired date of service
  
  • Name and demographics  
  • Spend-down, level of care, Medicare  
  • Third-party liability (TPL) information  
  • Managed care information  
  • Restricted information  
    ➢ Member is restricted to the providers listed  
  • Dental benefit limitations
### Web interChange

#### Eligibility Inquiry

<table>
<thead>
<tr>
<th>Query Information</th>
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<tbody>
<tr>
<td>Search For:</td>
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<tr>
<td>NPI</td>
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<tr>
<td>Search Criteria</td>
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<tr>
<td>Member ID</td>
</tr>
<tr>
<td>From Date</td>
</tr>
<tr>
<td>To Date</td>
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<table>
<thead>
<tr>
<th>Eligibility Information</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spend-Down</td>
<td>None</td>
</tr>
<tr>
<td>Managed Care Information</td>
<td>None</td>
</tr>
<tr>
<td>Member is restricted to</td>
<td>None</td>
</tr>
<tr>
<td>Third Party Carrier Information</td>
<td>None</td>
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<td>County Information</td>
<td>None</td>
</tr>
<tr>
<td>Benefit Limits Reached For Inquiring Provider Type</td>
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</table>
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
  • Retroactive eligibility
Claim Submission

Welcome to Web interChange - a secure website that allows you to inquire upon your Indiana Coverage Programs claim information quickly and easily.

**Claim Inquiry** allows you to inquire on your previously submitted claims - even before they make it to the RA. You can find your claim by searching within a date range, by claim type, member ID or by ICN. Once the basic claim information is displayed, simply click on that line to get the detailed information on that claim. In keeping with CMS privacy requirements, built-in security features allow only the billing provider to view the claims they submit.

**Claim Submission** allows you to electronically submit claims to the Indiana Health Coverage Programs via the Internet. All Institutional, Professional, and Dental claims can be entered on this site. This includes Inpatient, Outpatient, Home Health, Long Term Care, Medical, as well as Medicare Crossover claims.

**Eligibility Inquiry** allows you to inquire on the eligibility of an Indiana Health Coverage Programs Member utilizing a number of search criteria. The response will include eligibility information as well as other helpful fields such as Managed Care and TPL information.

**Care Select Notification Inquiry** allows Care Management Organizations to inquire on notifications entered for members.

**User Lists** allow you to build custom data lists to be used when electronically submitting claims to the Indiana Health Care Program via the Internet.

**Check/RA Inquiry** allows you to inquire on your previously received payments. You can find your check or Electronic Funds Transfer, as well as your Remittance Advice (RA), by searching within a date range or by searching for a
Web interChange – Claim Submission
Web interChange – Claim Submission

Detail Information

- Detail #
- * Date of Service: 05/27/2011
- * Procedure Code: D1110
- Tooth Number
- Surface
- * Units: 1.00
- * Charges: 75.00
- Rendering Provider
- Rendering NPI
- Rendering Taxonomy

Notes... Detail Benefits Info

Save Detail Reset Detail

Add Detail Delete Detail Copy Detail

Submit Claim Reset Claim Cancel Claim

Helpful Hints
- Use the NPI Reporting Tool to report your National Provider Identifier (NPI) to ICHP.
- Click on any field label to get more information about the field.
- Review the Help Page to find more information about how to use this site.
- Please direct comments, problems or suggestions concerning using this site to Indiana Medicaid.
Claim Submission

Claim notes example – 90-Day Provision

– 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 identification number (RID)
  • Name of the Third Party Liability billed
  • Dates of filing attempts
Claim Submission

Claim notes example – Retroactive Eligibility

– Use claim notes instead of a separate attachment when submitting claims for *Retroactive Eligibility*

  • When the claim is past the filing limit and the member was awarded retroactive eligibility

– Claims must be submitted within one year of the eligibility determination date

– Document in the claim note segment:

  • Member has retroactive eligibility
  • Please waive timely filing
Claim Notes Window

No attachment needed!
Claim Submission

Coordination of Benefits

– Coordination of Benefits (COB) information is **required** for TPL payments

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

– Access a TPL help guide on the Web interChange help page
Required Information

Coordination of Benefits

Name Of Insurance – No Spaces

Total Amount Paid On Claim

Primary Insurance ID
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
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
  • Void function is not available on denied claims
– A *replacement* is a change to an original claim, whether same day, same week, or post-financial
  • Electronic adjustment to a paid claim
  • Examples:
    ➢ Member information
    ➢ Procedure code
    ➢ Tooth/surface
    ➢ Billed amount
Voids and replacements related to claims in any known/ongoing audit (once the provider has been made aware of the audit)

- should be handled as directed by the OMPP SUR department
- Audit documentation will address this issue specifically
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 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 paper Adjustment Request Form to correct the claim
  - Refer to IHCP Provider Manual Chapter 10

**Note:** When the Replace This Claim feature is used more than one year after the date of service, a full recoupment may be applied to the claim
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
Check/RA 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 the paid claims associated with that check

– The most recent weeks’ RAs are displayed for four weeks

– Choose the PDF file to download the complete RA
Web interChange
Posting payments and re-filing claims

– Check all detail lines when posting IHCP payments to ensure all procedures are reimbursed
– Only resubmit denied details to avoid duplicate payments
– Resubmit using Web interChange
– Send paper claims to:

  Dental Claims
  P.O. Box 7268
  Indianapolis, IN 46207-7271
Web interChange

Check/RA inquiry

Welcome to Web interChange - a secure website that allows you to inquire upon your Indiana Health Coverage Programs claim information quickly and easily.

Claim Inquiry allows you to inquire on your previously submitted claims - even before they make it to the RA. You can find your claim by searching within a data field.

Claim Submission allows you to electronically submit claims to the Indiana Health Coverage Programs via the Internet. All Institutional, Professional, and Dental claims can be entered on this site. This includes Inpatient, Outpatient, Home Health, Long Term Care, Medical, as well as Medicare Crossover claims.

Eligibility Inquiry allows you to inquire on the eligibility of an Indiana Health Coverage Programs Member utilizing a number of search criteria. The response will include eligibility information as well as other helpful fields such as Managed Care and TPL information.

Care Select Notification Inquiry allows Care Management Organizations to inquire on notifications entered for members.

Presumptive Eligibility Member Assignment allows you to assign a PMP and MCO to a qualified Presumptive Eligibility applicant.

User Lists allow you to build custom data lists to be used when electronically

Administrators!

It has been more than 90 days since you last reviewed your group report information.

As an administrator for Web interChange, it is your responsibility to periodically review the access that you have provided to users within your organization(s). Please take a moment to review this information now by going to the Group Administration page and clicking on the View Group Report button.

To view more information regarding the group report, please visit the Membership FAQ page.

If you serve as an administrator to multiple organizations, please review the group report information for each.

What's New

Don't miss out Second Quarter Workshops will be starting in May. For session dates, times and descriptions visit us at: http://provider.indianamedicaid.com/general-provider-services/provider-education.aspx. Register to attend a workshop here: http://provider.indianamedicaid.com/hcp/workshop/index.aspx.
The most recent weeks’ RAs are displayed for four weeks

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<th>Provider ID</th>
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Check for Remittance Advice each week
Web interChange
True/False Quiz

- Eligibility Inquiry will display dental benefit limits that have been met
  True
- Eligibility Inquiry will not provide detail information on TPL coverage
  False
- 90 Day no response claims must be filed on paper with an attachment
  False
- Secondary claims in a paid status can be filed on the Web interChange
  True
- Only claims filed through Web interChange can be viewed in claim inquiry
  False
Web interChange

True/False Quiz

- Claims will not appear in claim inquiry on the web until after they appear on a Remittance Advice
  
  False

- A replacement claim can be submitted on the Web interChange as long as the last paid date is within one year

  False

- A voided claim will initiate a recoupment of the entire paid amount

  True

- Check/RA PDF files are only available for one week

  False
ADA 2006 Dental Claim Form

– Chapter 8, Section 5 of the IHCP Provider Manual details the requirements for the ADA 2006 claim form

– Report billing and rendering NPIs on the dental claim form:
  • Billing provider NPI field 49
  • Rendering provider NPI field 54

– Field 35 – TPL payment
### ADA 2006 Dental Claim Form

#### AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Patient/Guardian signature

Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Subscriber signature

Date

#### BILLING DENTIST OR DENTAL ENTITY

(Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

Dentist Name

Address 1

Address 2

City ST ZIP

49. NPI

#### ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment

☐ Provider’s Office ☐ Hospital ☐ EGF ☐ Other

39. Number of Enclosure

Radiograph(s) Oral In

40. Is Treatment for Orthodontics?

☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Place

42. Months of Treatment Remaining

43. Replacement of Prosthesis?

☐ No ☐ Yes (Complete 44)

44. Date Prior Placement

45. Treatment Resulting from

☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/YYYY)

47. Auto Accident

#### TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures & visits) or have been completed.

X Signed (Treating Dentist)

Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56A. Provider Specialty Code

Address

City ST ZIP

57. Phone Number ( )

58. Additional Provider ID
Prior Authorization

Prior authorization submission

– Prior authorizations may be submitted on the Web interChange
  • This function allows providers to submit PA requests via the web in a HIPAA-compliant format
  • Attachment feature must be used to submit supporting documentation

– Fax is the preferred method for submitting PA requests

– ADVANTAGE Health Solutions processes all PA requests for Traditional Medicaid
  • Paper requests should be faxed to:
    ➢ 1-800-689-2759
  • Mail PA requests for traditional Medicaid to:
    ➢ ADVANTAGE Health Solutions-FFS
      P.O. Box 40789
      Indianapolis, IN 46240
  • Or call 1-800-269-5720
Prior Authorization

- Dental Services are self-referral for Care Select members

- Mail PA requests for Care Select Medicaid to:
  - ADVANTAGE Health Solutions
    P.O. Box 80068
    Indianapolis, IN 46280
    Phone: 1-800-269-5720
    Fax request: 1-800-689-2759
  - MDwise
    P.O. Box 44214
    Indianapolis, IN 46244-0214
    Phone: 1-800-356-1204
    Fax request: 1-877-822-7186
# Prior Authorization

## Paper form

## Indiana Prior Review and Authorization Dental Request Form

<table>
<thead>
<tr>
<th>Requesting Provider #</th>
<th>Phone:</th>
<th>RID NO:</th>
<th>DOB:</th>
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</thead>
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<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/State/ZIP Code:</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

### Dates of Service

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<tr>
<th>START</th>
<th>STOP</th>
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</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
</tr>
</tbody>
</table>

### Service Code

<table>
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<tr>
<th>REQUETED SERVICE</th>
<th>PLACE OF SERVICE</th>
<th>UNITS</th>
</tr>
</thead>
</table>

### Caseworker

<table>
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<tr>
<th>Is Member Employed?</th>
<th>YES</th>
<th>NO</th>
<th>Circumstances (Place/Type):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is Member in Job Training?</td>
<td>YES</td>
<td>NO</td>
<td>Type of Job Training:</td>
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</tbody>
</table>

### Dental Treatment Plan

1. Endodontics – Indicate on diagram below the tooth/teeth to be treated by root canal therapy.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<td>21</td>
<td>20</td>
<td>19</td>
<td>18</td>
<td>17</td>
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</tbody>
</table>

Does the Member have missing teeth? YES □ NO □
Prior Authorization

Paper form

2. Periodontics – Evaluate the periodontal condition

3. Partial dentures (use chart to right to indicate teeth involved)
   A. Date or dates of extractions of missing teeth.
   B. Which teeth (use tooth number) are to be extracted?
   C. Which teeth (use tooth number) are to be replaced?
   D. Brief description of materials and design of partial.

4. Dentures (check one or both): Full upper denture Full lower denture
   A. How long edentulous
   B. Is member wearing dentures now? YES ☐ NO ☐ Age of present dentures

5. Describe treatment if different from above:

6. Is the member on parenteral/enteral nutritional supplements? YES ☐ NO ☐
   If YES, a plan of care to wean the member from the nutritional supplements must
   be attached. If the plan of care is not provided, dentures, partials, relines, and
   repairs will be denied.

Brief Dental/Medical History:

Signature of Requesting Dentist ___________________________ Date of Submission:

Mail to: http://www.indianamedicaid.com/ihcp/ProviderServices/PAAttachmentAddresses.aspx
Prior Authorization

Inquiry on Web interChange

– A requesting provider may inquire about all nonpharmacy 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
Requesting and service providers can use member ID to check status. All other providers must have the PA number to see authorization status.
Describe Dental Services
Dental Cap

– Currently, there is no annual dental cap for members, regardless of age
  • Procedure code specific benefit limits are still active
  • Refer to IHCP Provider Manual at indianamedicaid.com, Provider tab, Manuals page, Chapter 8, section 5
Managed Care Entities (MCEs)

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

  • Exception: 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 MCE after obtaining authorization

*CPT copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*
Spend-down

- The spend-down amount is deducted from the first claim processed by IndianaAIM
- 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
- Providers may **not** collect any portion of the spend-down in advance
Third Party Liability

– Always verify TPL information prior to providing services
  • The Eligibility Verification System (EVS) identifies active TPL for eligible members
  • Assignment of benefits should be on file for each member with TPL

– Providers may update TPL through Web interChange or by contacting the HP TPL Unit
  – Local (317) 488-5046
  – Toll free 1-800-457-4510
Third Party Liability

- If a third-party insurer makes a payment, the explanation of benefits (EOB) does not need to be submitted with the claim
  
  • Enter third-party liability (TPL) paid amount on the claim in field 35, or its electronic equivalent

- Include the EOB with the claim only when:
  
  • The primary insurer denies a service
  
  or

  • The primary insurer allows the charges but pays zero dollars
Third Party Liability

- IHCP makes payment on TPL claims only when the total Medicaid rate for the entire claim exceeds the amount paid by the primary insurer for the entire claim.

- IHCP reimbursement includes the lesser of the:
  - Difference between the IHCP rate and the TPL paid amount for the entire claim
  or
  - Amount billed on the claim
Third Party Liability

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 noncoverage of the service

– *Blanket denial* EOBs can be used until the end of the calendar year of the date of service and must contain the same procedure codes that are billed on the claim
Third Party Liability

90-Day Provision

– How to submit paper claims under the 90-Day Provision:
  • Write 90-Day Provision on the top of the claim
  • Boldly make a note on the attachment:
    ➢ Date of the filing attempt
    ➢ The words no response after 90 days
    ➢ Member identification number (RID)
    ➢ Provider’s National Provider Identifier (NPI)
    ➢ TPL billed
    ➢ Name of Insurance company billed
  • IHCP Provider Manual Chapter 5 contains billing instructions

– Insurance carrier reimburses IHCP member
  • 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 prior to receiving services
Third Party Liability

QMB – Qualified Medicare Beneficiary

– QMB members are eligible for Medicare and Medicaid
  • The State pays the premium for Medicare Part B

– Two Types:
  • QMB-Only – The IHCP pays “only” the Medicare coinsurance and deductible
    ➢ QMB-Only members do not have dental coverage as Medicare does not cover dental services
    ➢ Dental providers should have QMB-Only members sign a waiver prior to furnishing services
  • QMB-Also – The IHCP pays “also” for Medicare noncovered services in addition to the coinsurance and deductible
    ➢ Services must be covered by Medicaid to be reimbursed
What is covered under the IHCP Program?

Refer to the:

- *IHCP Fee Schedule*
- *IHCP Provider Manual Chapter 8, Section 5* to determine which Current Dental Terminology (CDT) codes are covered
Fee Schedule

– The IHCP Fee Schedule is available on the IHCP website at indianamedicaid.com

– Included on the fee schedule:
  • Pricing for procedure codes
  • Code descriptions
  • Prior authorization requirements for codes
Fee Schedule

Welcome

Welcome to the Indiana Health Coverage Programs (IHCP) provider Web site. On this site, you will find complete program information and requirements, as well as online access to enroll as a provider, submit and check claims, verify member eligibility, register for provider training, and much more. If you have questions, comments, or suggestions, please take a few minutes to provide us with Web Site Feedback (Contact Us > Web Site Feedback) - or talk to your IHCP Provider Relations representative.

News and Announcements

Attestation for EHR Meaningful Use for Eligible Providers Begins in July

07/24/2012 - Indiana Medicaid's Electronic Health Records (EHR) Registration and Attestation Portal will be enhanced in July to allow Year 2 Meaningful Use (MU) payment
Fee Schedule

IHCP Fee Schedule - Copyright Agreement

IMPORTANT NOTICE: Before you can view the Fee Schedule, you must accept the following agreement. If you accept, you will be sent to the Fee Schedule. If you do not accept, you will be returned to the IndianaMedicaid.com Home Page.

LICENSE FOR USE OF "Physicians' CURRENT PROCEDURAL TERMINOLOGY", FOURTH EDITION ("CPT")

End User/Point and Click Agreement:

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Fee Schedule

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The IHCP Fee Schedule has been enhanced to provide information regarding all CPT-4 Procedure codes, HCPCS and ADA codes currently recognized by the IHCP. This fee schedule is intended for use by providers who bill services on the HCFA 1500 Claim Form and the Dental Claim Form only. The information contained on this Fee Schedule does not pertain to providers who use the UB-92 or Pharmacy Claim form. Information for UB-92 and Pharmacy billers can be found in the IHCP Provider Manual, Chapter 7, Reimbursement Methodologies.

This is an interactive site that allows you to View the Entire Fee Schedule, or Search by Procedure Code, Procedure Code Range, or Procedure Code Description. The IHCP Fee Schedule includes a variety of search capabilities such as procedure code range and keywords, i.e., tooth, surgery, etc.

You can also download the entire Fee Schedule in a format that can be imported into several computer applications including Microsoft Excel and Microsoft Access. See the Fee Schedule instructions for more information on using this file.

Information regarding each procedure code, such as program coverage, the maximum allowed fee, prior authorization requirements, and anesthesia base units is available on the Fee Schedule.

Hospital Assessment Fee: In accordance with section 281 of Public Law 229-2011, the IHCP will implement a hospital assessment fee program effective July 1, 2011 through June 30, 2013. As a part of this program, fee-for-service claim reimbursement for eligible hospitals will be increased by applying
**Fee Schedule**

### IHCP Fee Schedule - Search

**Search by Procedure Code**

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.

- **Procedure Code:** D5110

**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.

* Code values are described on the Fee Schedule Instructions.

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:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Mod 1</th>
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<th>Mod 3</th>
<th>Mod 4</th>
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<th>Program Coverage</th>
<th>Program PA</th>
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</table>

- Fee Schedule Amt: $743.38
- Anesthesia Base Unit: 0

- Fee Schedule Amt: $414.53
- Anesthesia Base Unit: 0
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

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.
Understand Dental Policy
Use the following codes to bill for evaluations:

- **D0120** – Periodic Oral Evaluation
  - One visit per member every six months, irrespective of age

- **D0150** – Comprehensive Oral Evaluation
  - New or established patient or D0160 Extensive Oral Exam
  - Limited to one per lifetime, per member, per provider with an annual limit of two per member

- **D0140** – Emergency Oral Exam
  - Enter the word *Emergency* in field 2 of the ADA 2006 dental claim form - Required for package E
Dental Policy

Fluoride

– For fluoride services:

  • D1203 – Topical application of fluoride – Child (ages 1 through age 12)

  • D1204 – Topical application of fluoride – Adult (ages 13-20)

– Topical application of fluoride is not covered for members age 21 and above
Dental Policy

Prophylaxis

– Use the following codes to bill for prophylaxis:
  
  • **D1120** – Prophylaxis - Child (ages 1-11)
  • **D1110** – Prophylaxis - Adult (ages 12 and older)

– The IHCP covers **one cleaning every six months** for members **20 years old and younger**, and **one cleaning every 12 months** for members **21 years and older**

– If the member is **institutionalized**, he or she is eligible for **one cleaning every six months**
Dental Policy
Periodontal scaling and root planing

D4341 is limited to:

– Four units every two years for members aged 3-20
– Four units per lifetime for members aged 21 and older
– Four units every two years for institutionalized members
Dental Policy
Periodontal scaling and root planing

– Claims submitted for procedure code D4341 must have perio charting to support the procedure

– Perio charting should include:
  • Member name and Medicaid number
  • Date of service

– Do not include quadrants on the detail lines

– Quadrant limitation verification is available on the EVS and is noted only after the fourth quadrant is paid
  • EVS does not indicate the benefit limit until after the full benefit is met (four units)

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

Sealants

- The IHCP only covers procedure code \textit{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 tooth number detail for paid sealants
Dental Policy

Multiple restoration reimbursement

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

– For example, the IHCP reimburses for only one of the appropriate procedure codes (D2140, D2150, D2160, D2161) for an amalgam restoration of primary tooth letter

– 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
Dental Policy

Extractions

– The IHCP reimburses 100% 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% of the maximum allowed amount for procedure code D7140 or the billed amount, whichever is less

– Bill only one tooth number per detail line
Dental Policy

Supernumerary tooth extraction

– Effective January 1, 2010, the IHCP adopted the ADA tooth designations for supernumerary tooth extractions
– Eliminates the necessity to bill D7999
Dental Policy

Claim notes for supernumerary tooth extraction

*Permanent dentition – Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar*

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<th>4</th>
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Dental Policy

Claim notes for supernumerary tooth extraction

*Primary dentition – Supernumerary teeth are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (supernumerary “AS” is adjacent to “A”)*

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<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
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<td>BS</td>
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<td>OS</td>
<td>NS</td>
<td>MS</td>
<td>LS</td>
<td>KS</td>
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Dental Policy

X-Rays

405 IAC 5-14-3 (2) - Bitewing radiographs are limited to

- one (1) set per recipient every twelve (12) months.

One (1) set of bitewings is defined as either:

- (A) four (4) horizontal films; or
- (B) seven (7) to eight (8) vertical films
Dental Policy

Dentures

- Dentures and replacement require PA
  - Members 20 years old and younger do not require PA for dentures
  - Medical necessity should be documented in the chart
- Requests for relines or repairs may be approved if they will extend the useful life of a prosthesis
- The delivery date is the date of service for each service
- Providers should always verify member eligibility prior to rendering services
  - Providers may charge the member for dentures if the member is ineligible upon delivery
  - A waiver is not required, but is suggested
Dental Policy

Orthodontia

– All orthodontic procedures require PA
  • The IHCP authorizes PA on a case-by-case basis

– 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 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
Dental Policy

General anesthesia

**D9220** and **D9221** (General Anesthesia) is reimbursable

- Per 405 IAC 5-14-15, Medicaid reimbursement is available for general anesthesia
- Per 405 IAC 5-3-13, dental services rendered in an inpatient setting require prior authorization
Dental Policy

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
Understand

Common Returned Claims and Denial Reasons
Return to Provider (RTP) Claims

- If you receive claims back with a cover letter, your claims have not been entered into the claims processing system.
- The following are examples of the top reasons claims are returned to providers.

Invalid NPI

- Verify that all paper claim submissions contain the correct NPI in the following fields of the ADA 2006 claim form:
  - Field 49: Enter the NPI of the group or billing provider
  - Field 54: Enter the NPI of the rendering provider
RTP Claims

Illegible handwriting

- HP will accept claims that are handwritten
  - If submitting handwritten paper claims, be sure the writing is clearly legible and all information is inside the field line
- Do not use red ink

RID number missing

- Verify that all paper claim submissions contain the RID in field 15 of the ADA 2006 dental claim form
- Claim field instructions are found in Chapter 8, Section 5 of the IHCP Provider Manual for the ADA 2006 claim form
Edit 5001

Exact Duplicate

– Cause

• When the claim being processed is an exact duplicate of a claim on the history file in a paid status

– Resolution

• Review claims submitted to identify claim in paid status
  ➢ Review Claims Inquiry on Web interChange using the member RID and dates of service
  ➢ Review past-dated Remittance Advices
Edit 4034

Procedure code vs. age restriction

– Cause
  • Procedure code listed is designated for a particular age range that does not coincide with the age of the member on the claim
    ➢ For example, if a member is 10 years old and a D1110 is billed, this edit will cause the claim line to deny

– Resolution
  • Research the age and benefit limitations detailed in the IHCP Provider Manual in Chapter 8, Section 5
Edit 6265

BITEWING X-RAYS ARE LIMITED TO FOUR HORIZONTAL OR SEVEN TO EIGHT VERTICAL IN A TWELVE MONTH PERIOD

Cause

• procedure code D0273-Bitewing three films, more than one film in a year.
  ➢ If procedure code D0273 is billed with more than one unit in a years’ time frame, the claim will cutback and pay the one unit and deny the additional units billed
  ➢ Horizontal bitewing x-rays are limited to four every 12 months

Resolution

• Verify Eligibility
  ➢ Check the benefit limits reached
  ➢ Review past x-ray services
Edit 0513

Recipient name and number disagree

- **Cause**
  - The member number and the member name on the claim do not match what is listed on the recipient eligibility

- **Resolution**
  - Check the Eligibility Inquiry on Web interChange and verify all information on the claim matches the eligibility information exactly
Recipient covered by private insurance

- **Cause**
  - The claim does not contain either (1) indication of the primary insurance payment or
    (2) a copy of the primary insurance EOB form

- **Resolution**
  - Verify eligibility using Web interChange to determine what primary insurance should be
    billed; after obtaining payment or denial from the primary carrier, rebill for adjudication
    through the IHCP
  - Providers can either file the claim:
    - Using Web interChange when a payment has been made (no attachment needed)
    - Refiling the claim on the Web interChange with a paper attachment using the
      attachment process
    - Refiling the claim on a paper claim form including the primary EOB behind the
      claim form
  - When primary insurance denies or pays zero on a claim, providers will need to include
    the primary insurance EOB with their claim
Find Help

Resources Available
Helpful Tools
Avenues of resolution

– IHCP website at indianamedicaid.com

– IHCP Provider Manual
  – Chapter 8, Section 5

– IHCP Fee Schedule

– 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

– Locate area consultant map on:
  • indianamedicaid.com (provider home page> Contact Us> Provider Relations Field Consultants)
  or
  • Web interChange > Help > Contact Us
Q&A