Agenda

• Define Objectives
• Eligibility Verification
• Coverage and Billing Procedures
  ➢ Examinations
  ➢ Code Sets
• Lenses and Frames
• Benefit Limit Verification
• Prior Authorization
• Error Codes and Common Denials
• Find Help
• Q&A
Objectives

Upon completion of this session, providers will be able to:

• Understand coverage, billing, and reimbursement issues for ophthalmological services
• Understand the importance of verifying eligibility and understand benefit limitations
• Understand error codes and the most common reasons for claim denials
• Understand Medicaid rules regarding lenses, frames, and replacement eye glasses
• Understand when it is appropriate to bill a Medicaid recipient for services
References

- Ophthalmological services are outlined in the IHCP Provider Manual, *Chapter 8*, Section 4 at indianamedicaid.com
- **405 IAC 5-23** (Indiana Administrative Code)
Verify Eligibility
2014 Medicaid eligibility changes

- Effective June 1, 2014, Indiana made significant changes in eligibility requirements
- Changes affect current beneficiaries and future applicants for Indiana Medicaid in the aged, blind, and disabled categories
- Indiana changed from a “209(b)” to a “1634” state
- 1634 transition results:
  - Significant net savings to Indiana
  - Eliminated spend-down program
  - More members receive more comprehensive coverage
- For detailed information, see the FSSA website at in.gov/fssa
Verifying Eligibility

- The 1634 transition makes it even more critically important to verify eligibility each time you provide a service
  - Call the Automated Voice Response (AVR) System at 1-800-577-1278, Option 4
  - Web interChange
  - Omni system has been discontinued
- Be sure to know which aid categories cover mental health services
Web interChange – Eligibility Inquiry

Eligibility Inquiry

Query Information

- Search For: NPI (radio button selected)
- Taxonomy Code
- Postal Code
- Search Criteria: By Member ID
- Member ID
- From Date: 04/01/2014
- To Date: 04/01/2014

Eligibility Information

- Member is Eligible from 04/01/2014 to 04/01/2014 for PACKAGE A STANDARD PLAN
- Inquiry completed at 2:42:00 PM on 7/1/2014

Member Information

- Member Name
- Address
- Date of Birth
- Spenddown/HCBS Waiver Liability: No
- Medicare: No
- Nursing Home Resident: No
- Restricted: No
- QMB: No
- Other Private Insurance: No
- Medicare Number
- Patient Liability
- None
- None

Managed Care Information

- None
Aid Categories that cover Vision Services

• Package A Standard Plan
  – Former foster children
  – Pregnancy
  – Parent caretaker
  – Hospital Presumptive Eligibility (HPE) infant
  – HPE children
  – HPE parent caretaker
  – HPE former foster children
  – Supplemental Security Income
• Package C - Children’s Health Insurance Plan (CHIP)
• QMB-Also
• 590 Program (prior authorization required if over $500 per procedure)
Aid Categories that do not cover Vision Services

- Package E – Emergency services
- Package H – Healthy Indiana Plan
- Package P – Pregnancy
  - Presumptive Eligibility Pregnant Women (PEPW)
  - Hospital Presumptive Eligibility Pregnant Women (HPE)
- Family Planning
  - HPE Family Planning
- Medicare Coinsurance Deductible Only (OMB-Only)
Coverage and Billing Procedures
Coverage and Billing Procedures

- The Indiana Health Coverage Programs (IHCP) provides reimbursement for ophthalmology services, subject to the following restrictions:
  - One routine vision care examination and refraction for members 20 years old and younger, per rolling 12-month period
  - One routine vision care examination and refraction for members 21 years old and older, per rolling 24-month period
  - Vision examinations may be performed more often than the 12 and 24-month periods described previously if they are medically necessary and billed with a medical diagnosis
Coverage and Billing Procedures

• Eyeglasses
  – One pair of eyeglasses for recipients age 20 years old and younger, per year
  – One pair of eyeglasses for recipients 21 years and older, every five years
Routine Examinations

Common error codes

- The routine examination limitations will apply and hit these error codes, when certain procedure codes and diagnosis codes are billed together
  - Error code 6297 – Routine vision exam limited to one per 12 months, age 1-20
  - Error code 6298 – Routine vision exam limited to one per 24 months, age 21 and over
Routine Examinations

Procedure codes and diagnoses codes considered routine examinations

- **Procedure codes:** 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99241-99245, 99251-99255, 99302-99306, 99318, 99321-99323, 99341-99345, 99347-99350, 99381-99387, and 99391-99397

- **Diagnosis codes:** 367, 3670, 3671, 3672, 36721, 3674, 3675, 36753, 3678, 36789, 3679, V41, V410, V411, V72, V720, V80, V801, and V802
Coverage and Billing Procedures

- Providers must use the appropriate Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes when submitting claims for vision services.

- Optometrists and opticians are subject to vision service code sets, which are available at indianamedicaid.com:
  - Specialty 180 (optometrists)
  - Specialty 190 (opticians)

*CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*
Provider Code Sets

• The IHCP established provider code sets for opticians (specialty 190) and optometrists (specialty 180)
  – Enrolling in the 190 specialty does not necessarily cover services in the 180 specialty
  – Enrolling in the 180 specialty does not necessarily cover services in the 190 specialty

• Providers must ensure that they are enrolled as the correct provider type and specialty and bill the appropriate code set

• Type and specialty can be verified using the Provider Profile menu option on Web interChange
Optician Code Sets

Vision Services Code Set
Optician (190)
Effective October 1, 2004
Last Updated August 15, 2011

1. Codes listed with an asterisk (*) must be performed under direction supervision of physician or optometrist.
2. New codes added during the 2005 Annual Update are indicated with **bold text**.
3. Codes description revisions per the 2005 Annual HCPCS Update are indicated by *italic text*.
4. Refer to IHCP Provider Bulletins BT200430 and BT200433 for more information regarding the 2005 Annual HCPCS Update. These bulletins and other relevant publications are available online at www.indianamedicaid.com.
5. A listing on this table does not necessarily indicate coverage. Please refer to the IHCP Provider Manual, IHCP newsletters, banners, and bulletins, and the IHCP Fee Schedule for updates to coverage and benefit information.

_Please note:_ Effective December 1, 2004, V2760, V2782, V2783, and V2786 will be non-covered.

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>V2020</td>
<td>FRAMES, PURCHASES</td>
</tr>
<tr>
<td>V2025</td>
<td>DELUXE FRAME</td>
</tr>
<tr>
<td>V2100</td>
<td>SPHERE, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00, PER LENS</td>
</tr>
<tr>
<td>V2101</td>
<td>SPHERE, SINGLE VISION, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D, PER LENS</td>
</tr>
<tr>
<td>V2102</td>
<td>SPHERE, SINGLE VISION, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D, PER LENS</td>
</tr>
<tr>
<td>V2103</td>
<td>SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS</td>
</tr>
</tbody>
</table>
# Optometrist Code Sets

## Vision Services Code Set

**Optometrist (180)**  
Last Updated November 12, 2012

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

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<tr>
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<tr>
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</tr>
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</tr>
<tr>
<td>V2101</td>
<td>SPHERE, SINGLE VISION, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D, PER LENS</td>
</tr>
<tr>
<td>V2102</td>
<td>SPHERE, SINGLE VISION, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D, PER LENS</td>
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<td>V2104</td>
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<td>V2105</td>
<td>SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS</td>
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</table>
Coverage and Billing Procedures

• Many vision procedure codes are on the Medicare bypass table
  - Claims for "dually eligible" do not have to be billed to Medicare first (unless they have QMB-Only or QMB-Also)
  - Exams/services (92002, 92004, 92012, 92014, 92015, 92065, 92315, and 92316)
  - Frames (V2020 and V2025)
  - Lenses (V2100-V2615)
Ophthalmologic Uses of HCPCS Code J3300

- The IHCP provides coverage for ophthalmologic use of HCPCS code J3300-Injection, triamcinolone acetonide, preservative free, 1 mg
- J3300 is distributed in single-dose vials of 40 mg
- In cases where less than 40 mg is injected, due to unavoidable waste, providers may bill the entire 40 mg
  - Amount used and amount wasted must be documented in medical record
- J3301-Injection, triamcinolone acetonide, not otherwise specified may be used for non-ophthalmologic purposes
Coverage and Billing Procedures

Dates of Service Definition

- All claims must reflect a date of service, which is the date the specific services were actually supplied, dispensed, or rendered to the patient.
- The date of service billed for eyeglasses must be the date the glasses were given to the recipient.
Eye Examination

• The eye examination includes the following services, and providers should not bill them separately:
  – Bioculcular measurement
  – External eye examination
  – Gross visual field testing including color vision, depth perception, or stereopsis
  – Routine ophthalmoscopy
  – Tonometry
  – Visual acuity determination
Billing Eye Examinations with Counseling and Coordination of Care

• Providers may code examinations in which counseling and coordination of care are the dominant services with the appropriate evaluation and management (E/M) code using the time factor associated with the code.

• Documentation in the patient’s record must include the total time of the encounter and a synopsis of the counseling topics and coordination of care efforts.

• Eye examination including counseling and coordination CPT codes are the following:
  - 99201 – 99215
  - 99241 – 99245
  - 99251 – 99255
  - 92002 – 92014
Routine Vision vs. Medical Examinations

• The diagnosis code related to the specific procedure code should reflect the conditions treated only on that date of service
  – Example: A patient is seen for a swelling or mass of the eye (379.92), but has a history of myopia (367.1)
• If myopia (nearsightedness) is not evaluated or treated during the current visit, use only diagnosis code 379.92
• If diagnosis code 367.1 is included on the claim, the claim will be considered a routine exam subject to the limitations
Routine Vision vs. Medical Examinations

- When a patient is seen for a medical and routine vision service on the same date, the primary reason for the encounter should be used to determine whether the service falls under the routine or medical benefit.
- If the primary reason for the visit was swelling or mass of the eye, but a routine vision exam and refraction were performed, the exam should be coded with the swelling and mass of the eye (medical) diagnosis, and the refraction should be coded with the routine diagnosis.
Lenses
Lenses

- Providers should include prescription of lenses, when required, in HCPCS code 92015 – *Determination of refractive state*, which includes specification of lens type (monofocal, bifocal, or other), lens power, axis, prism, absorptive factor, impact resistance, and other factors
Lenses

Bundled services

- The IHCP considers the following services bundled and not separately billable to the IHCP or the patient:
  - Eyeglass cases
  - Fitting of eyeglasses
  - Neutralization of lenses
  - Verification of prescription
  - Fitting for contact lenses
Lenses

Noncovered

• The IHCP does not cover the following:
  - V2702 – Deluxe lens feature
  - V2744 – Tint, photochromic
  - V2750 – Antireflective coating
  - V2760 – Scratch resistant coating
  - V2781 – Progressive lenses
  - V2782 – Lens, index 1.54-1.65 plastic, or 1.60 to 1.79 glass
  - V2783 – Lens, index >= 1.66 plastic, or >= 1.80 glass
  - V2786 – Specialty multi-focal lens

• If a member chooses to upgrade to one of these codes:
  - Provider bills the IHCP for the basic lens code
  - Provider may bill the member for the upgrade portion as long as noncoverage is explained and a waiver is signed in advance
Lenses

• The IHCP only reimburses for tints 1 and 2
  – V2745 U1 – Tint, plastic, rose 1 or 2, per lens
  – V2745 U2 – Tint, glass, rose 1 or 2, per lens

• The IHCP covers safety lenses only for corneal lacerations and other severe intractable ocular or ocular adnexal disease
Lenses
Polycarbonate lenses – HCPCS V2784

• Are covered only for medically necessary conditions that require additional ocular protection; for example:
  − Member has carcinoma in one eye, and the healthy eye requires corrective lens
  − Member has eye surgery and still requires corrective lens
  − Member has low vision or legal blindness in one eye with normal or near normal vision in the other eye
  − Other conditions deemed medically necessary, that must be such that one eye is affected by an intractable ocular condition, and the polycarbonate lens is being used to protect the remaining vision of the healthy eye

  Note: Medical necessity must be documented in the patient chart
Lenses – error codes

- **Error code 6271** – *Lenses initial or replacement – recipient age 0-20* (if more often than one per year)
  - Procedure codes
    - V2100 – V2218
    - V2220 – V2599
    - V2780

- **Error code 6272** – *Lenses initial or replacement – age 21 and over* (if more often than one every five years)
  - Procedure codes
    - V2100
    - V2102
    - V2203 – V2430
    - V2499
    - V2500 – V2530
    - V2780
Lenses

Contact lenses

• Are covered when medically necessary
• Examples of medical necessity:
  – Severe facial deformity
  – Severe allergies to all frame materials
• Providers can bill the following codes, in addition to general ophthalmology services:
  – 92310 through 92313 for prescription of optical and physical characteristics of and fitting of contact lens
  – 92314 through 92317 for prescription of optical and physical characteristics of contact lens, with medical supervision
  – 92325 for modification of contact lens, with medical supervision of adaptation
  – 92326 for replacement of contact lens
• Patient charts must support medical necessity
Frames

• The IHCP reimburses for frames including, but not limited to, plastic or metal
  – Procedure code V2020
• Deluxe or fancy frames are covered only when medically necessary
  – Procedure code V2025
    ➢ Examples
      o Facial deformity
      o Allergic reaction to standard frame material
      o Provision of special sized frames for an infant
  – Submit an invoice with the claim; reimbursement is 90% of retail price
• If the member chooses to upgrade to a deluxe frame, the entire frame is noncovered, and the member can be billed
  – Member must sign a waiver prior to service being rendered
Frames – error codes

- **Error code 6196** – *Frames initial or replacement – recipient age 0-20* (if more often than one per year)
  - Procedure codes
    - V2020
    - V2025

- **Error code 6195** – *Frames initial or replacement – age 21 and over* (if more often than one every five years)
  - Procedure codes
    - V2020
    - V2025
    - V2799
    - V5230
    - 92370
Replacement Eyeglasses

- Members who have met medical necessity guidelines for replacement eyeglasses are eligible for a new pair of eyeglasses:
  - Younger than 21 years of age: eligible for a replacement pair of eyeglasses each year
  - 21 years of age and older: eligible for a replacement pair of eyeglasses every five years
- The member must meet the following medical necessity guidelines in at least one eye for the provision of eyeglasses, including replacements:
  - A change of 0.75 diopters for patients 6 to 42 years old
  - A change of 0.50 diopters for patients more than 42 years old
  - An axis change of at least 15 degrees
Modifiers for Replacement Eyeglasses

- Replacement eyeglasses due to loss, theft, or damage beyond repair, prior to the frequency guidelines, should be billed with modifier **U8**
  - Documentation that eyeglasses have been lost, stolen, or broken beyond repair must include a signed statement by the member detailing how the eyeglasses were lost stolen or broken

- Replacement eyeglasses due to change in prescription, prior to the frequency guidelines, should be billed with modifier **SC**

- Use of either modifier indicates appropriate documentation is on file in the patient’s record to substantiate the need
Benefit Limitation Verification
Billing Members

• Providers may bill IHCP members for services exceeding the benefit limitations under the following circumstances:
  - If the Eligibility Verification System (EVS) shows that a limitation has been met:
    ➢ Inform the member the service will be noncovered and he or she will be billed
    ➢ Have the member sign a waiver
  - If EVS does not show that benefits have been exhausted:
    ➢ Provider may ask the member or guardian to attest in writing that they have not received the service within the past one or five years (depending on age)
    ➢ Inform the member if he or she is misrepresenting, and the claim is denied; the member will be responsible for the charges
Benefit Limits Reached

*Web interChange* eligibility screen shows benefit limits reached
## Benefit Limits Reached

<table>
<thead>
<tr>
<th>EOB Code</th>
<th>EOB Description</th>
<th>Web Display</th>
<th>Web Display Show More</th>
</tr>
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<tbody>
<tr>
<td>6297</td>
<td>ROUTINE VISION EXAMS ARE LIMITED TO ONE (1) PER TWELVE (12) MONTHS FOR AGES 1 TO 20 YEARS.</td>
<td>Optometry - Exams</td>
<td>Optometry - Eye Exams age 20 or under</td>
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<tr>
<td>6298</td>
<td>ROUTINE VISION EXAM LIMITED TO ONE PER TWENTY-FOUR (24) MONTHS FOR AGES 21 AND OVER.</td>
<td>Optometry - Exams</td>
<td>Optometry - Eye Exams age 21 or older</td>
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<tr>
<td>6195</td>
<td>FRAMES INITIAL OR REPAIR/REPLACEMENT- RECIPIENT OVER 21 YEARS OF AGE</td>
<td>Optometry - Frames</td>
<td>Optometry - Frames age 21 or older</td>
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<td>FRAMES INITIAL OR REPLACEMENT-RECIPIENT AGE 1 TO 20</td>
<td>Optometry - Frames</td>
<td>Optometry - Frames age 20 or under</td>
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<td>6271</td>
<td>LENSES INITIAL OR REPLACEMENT- RECIPIENT 20 YEAR OR YOUNGER</td>
<td>Optometry – Lenses</td>
<td>Optometry - Lenses age 20 or under</td>
</tr>
<tr>
<td>6272</td>
<td>LENSES INITIAL REPAIR/REPLACEMENT MEMBER OVER 21 YEARS OF AGE</td>
<td>Optometry – Lenses</td>
<td>Optometry - Lenses age 21 or older</td>
</tr>
</tbody>
</table>
Written Correspondence

• Providers may send an inquiry to the HP Written Correspondence Unit to determine if a member has exceeded service limitations
  − HP Provider Written Correspondence
    P.O. Box 7263
    Indianapolis, IN 46207-7263
• Allow 10 business days for a response
  − Responses are mailed to the “Pay To" address
• Use the IHCP Inquiry Form on the Forms page at indianamedicaid.com
  • http://provider.indianamedicaid.com/media/29989/inquiry.pdf
EVS – Benefit Limits Reached

• The Benefit Limits Reached information on vision services contained in the EVS may not always be up to date on members covered by the Hoosier Healthwise, risk-based managed care program
• Providers should contact the managed care entity (MCE) vision plan to inquire about vision services benefit limits
Business Practice to Restrict Services

• Providers may establish a business practice to refuse or restrict certain services that are provided to the general public
• The provider must establish a written policy to do so
• If a provider intends to provide exams, diagnostic services, or surgical services but will not provide eyewear, the member must be advised at the time the appointment is made that the provider does not provide “IHCP approved glasses"
• A prescription may be provided for the member to have filled at a participating eyewear provider, or the member may choose to find another provider that will furnish both services
Prior Authorization
Prior Authorization

• For Traditional Medicaid, prior authorization (PA) is not required for vision care services except for the following provisions:
  – Blepharoplasty for a significant obstructive vision problem
  – Prosthetic device, except eyeglasses
  – Reconstruction or plastic surgery

• Contact ADVANTAGE Health Solutions for PA for Traditional and Care Select members
  – Telephone: 1-800-269-5720   Fax: 1-800-689-2759

• **Risk-based MCEs may have additional PA requirements**
Right Choices Program

• The Right Choices Program (RCP) is designed to provide high-intensity member education, care coordination, and utilization management to recipients identified as overusing or abusing services.

• Certain services are not typically included in the coordination by the RCP and can still be accessed on a self-referral basis.

• These services would not require written referral unless a recipient is going to receive prescriptions from the provider.

• If the provider writes a prescription that will be dispensed at a pharmacy, a referral is necessary for the prescription claim to be paid.

• *Vision services, except for surgery, do not require a referral*
Most Common Denials

Top 10 denials - January to May 2014
## Provider Type 18 - Optometrist

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Description</th>
<th># Claims</th>
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<tbody>
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<td>Medicare denied detail</td>
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<td>4021</td>
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<td>Recipient covered by private insurance</td>
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<td>DOS not on PA database</td>
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<td>Rendering provider specialty not eligible to render procedure code</td>
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<td>Rendering provider must have an individual number</td>
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## Provider Type 19 - Optician

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<td>513</td>
<td>Recipient name and number disagree</td>
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<tr>
<td>6195</td>
<td>Frames initial or replacement 21 years and older</td>
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<td>2001</td>
<td>Recipient number not on file</td>
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<td>Rendering NPI must be submitted</td>
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<td>Coinsurance and deductible amount missing</td>
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## Provider Specialty 330 - Ophthalmologist

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<td>2505</td>
<td>Recipient covered by private insurance</td>
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<td>4300</td>
<td>Invalid NDC to procedure code combination</td>
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<tr>
<td>6000</td>
<td>Manual pricing required</td>
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<tr>
<td>1130</td>
<td>Ordering/Prescribing/Referring provider in not enrolled in IHCP</td>
<td>886</td>
</tr>
</tbody>
</table>
Helpful Tools

• IHCP website at indianamedicaid.com
• *IHCP Provider Manual* at indianamedicaid.com
• EVS Technical Support
  – HP Electronic Solutions Help Desk at 1-877-877-5182
• Customer Assistance
  – 1-800-577-1278
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