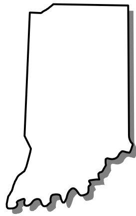

IMPORTANT INFORMATION

BR200426 JUNE 29, 2004

To All Providers:

- The Indiana Health Coverage Programs (IHCP) has received questions from trading partners about comparisons between the paper remittance advice (RA) and the 835 electronic transaction. The paper RA reports only dollar amounts without balancing concerns. This dollar amount reflects prior payment information including spend-down, third party liability (TPL), and Medicare payments; or Medicare co-insurance or deductible as submitted with the original claim.
  There are different methods of reporting adjustments in the CAS segments of the 835 transaction. *Per the Data Overview Section of the 004010X091 – 835 – Health Care Claim Payment/Advice Transaction, Version 4010 Implementation Guide and the 4010A1 Addenda, Section 2.1.4 – Remittance,* "The 835 must be balanced whenever remittance information is included in an 835 transaction." *Section 2.2.1 – Balancing*, in the same section of the 835 implementation guide states "The amounts reported in the 835, if present, MUST balance at three different levels." Because the guide does not address the issue of populating the 835 CAS segments, the decision was made to use the method described in the 4050 draft version of the 835 guide. Per this guide, the IHCP will only report for balancing purposes the amount of prior payment, spend-down, TPL, and Medicare payments, or Medicare co-insurance or deductible in the 835 transaction up to the amount that would have been paid for the service.
  The intent of this approach is to minimize the risks of future changes with newer versions of the 835 transaction. There are no planned changes to the paper RA or 835 transaction at this time. For a technical example of the IHCP 835 transaction adjustment information related to the balancing methodology identified in the 4050 draft version of the 835 guide, please refer to the Frequently Asked Questions within EDI Solutions of the IHCP Web site.
- The *HealthWatch Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)* provider manual for immunization and screening table incorrectly lists Current Procedural Terminology (CPT) code 80100 for HIV testing and screening. The following CPT codes should be used for this procedure:
  - 86701 – HIV-1
  - 86689 – HIV antibody confirmatory test (e.g., Western Blot)

  This correction will be reflected in the next revision of the *HealthWatch/EPSDT* provider manual. Please direct any questions to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1228.
- The IHCP has removed postoperative pain management codes, CPT codes 62310, 62311, 62318, 62319, 64412-64417, 64420, 64421, and 64445-64450, from audit *6666 – Anesthesia services not allowed by provider billing for surgery*. Claims submitted with anesthesia procedure codes and these procedure codes should now reimburse appropriately. Modifier *59 – Distinct procedural service*, should be used in conjunction with postoperative pain management codes billed on the date of surgery.
- As a reminder, EDS changed banks from Huntington National Bank to Fifth Third Bank effective January 1, 2004. Provider checks issued before January 1, 2004, will stale date on July 1, 2004. In order to prevent checks issued prior to January 1, 2004, from stale dating, providers must present them prior to July 1, 2004.
- Effective October 16, 2003, State-assigned occurrence codes 50-69 were discontinued due to Health Insurance Portability and Accountability Act (HIPAA) requirements. In the interim, IHCP will continue to use these non-HIPAA codes on UB-92 paper claim forms and 837I electronic transactions until an alternative method of processing claims requiring these codes has been established. The IHCP is establishing new billing requirements for claims affected by the elimination of these codes. Providers will be notified of the new billing requirements when they have been established.

To Home Health Providers:

- The purpose of this article is to clarify billing units of home health visits for therapists, home health aides (HHA), license practical nurses (LPN), and registered nurses (RN).
  - For therapy visits – If the therapist is in the home eight minutes or more, then the visit can be rounded up to the 15-minute unit of service. If the therapist is in the home for seven minutes or less, this cannot be rounded up and therefore cannot be billed.
  - For HHA, LPN, or RN visits – If the HHA, LPN, or RN is in the home for less than 29 minutes, the entire first hour can be billed. This can only be done if a service was provided. For subsequent hours in the home, use the partial unit procedure as outlined in the *IHCP Provider Manual,* chapter 8, section 8, page 42. For example: If an RN went into the home and a service was provided, but the RN was only there for 20 minutes, you may bill one unit of service. If the RN went into the home and was there for one hour and 20 minutes, you may only bill for one unit of service.

  If the therapist, HHA, LPN, or RN goes to the home and the member refuses service, the provider may not bill for any unit of service. Overheads are linked with reimbursement for services provided. Since a service was not provided, an overhead cannot be reimbursed.

To Federally Qualified Health Centers and Rural Health Clinics:

- Effective January 1, 2004, the following CPT codes, 76815, 76817, 76819, 76830, 76831, and 76856, will be added to the current list of valid Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) encounter codes as listed in the IHCP provider bulletins, *BT200327,* published May 13, 2003, and *BT200357*, published August 29, 2003. Additionally, effective January 1, 2004, the following CPT and Healthcare Common Procedure Coding System (HCPCS) codes are no longer valid Medicaid codes and therefore, will be removed from the list of valid encounter codes: 10040, 15787, 94665, W0660, 90820, 90843, 99450, W0661, 90844, 99455, X3006, and 15786.
  The valid FQHC and RHC encounter code list is reviewed on an annual basis. For the 2005 annual code review, providers should submit any requests to include additional codes on the current list of valid encounter codes to Alice Rae of the Indiana Primary Health Care Association, (317) 630-0845 by December 15, 2004. Please note that any requests received subsequent to this banner page will be reviewed during the 2005 annual code review.
  For additional information, please direct questions regarding the above information to Christina Henderson at Myers and Stauffers LC at (317) 846-9521 or 1-800-877-6927.

To Hospice Providers:

- Effective July 1, 2004, hospice providers will be required to modify the way they bill for the date of death. When billing a date of service that is the same as the date of death (for those recipients residing in a Nursing Facility), hospice providers will bill occurrence code 51 in field 32a on the UB 92 claim form, along with the date of death. The system has been modified to no longer pay for the date of death for hospice services for those recipients residing in Nursing Facilities. However, by billing occurrence code 51 with the date of death, the system will <u>only pay for hospice services</u> for the date of death for revenue codes 653 and 654. Without occurrence code 51, providers will receive explanation of benefits (EOB) 9069 – *Room and Board not paid on date of death/discharge*, when they bill revenue codes 653 or 654 for date of death. Without occurrence code 51, the system will deny revenue code 659 if it is the same date as the date of death. Providers will receive EOB 4233 – *Date of death/discharge not covered*, when they bill revenue code 659 for date of death. For questions, please contact Customer Assistance Unit at (317) 655-3240 or 1-800-577-1278.

To Medical and Home Health Providers:

- Medical and Home Health claims did not process as expected with posted EOB *3001 – Dates of service not on PA master file* or with an EOB associated with a specific benefit limit where the claim denied because a prior authorization was on file. The issue relating to adjudicated claims that created underpayments between May 25, 2004, and June 8, 2004, has been corrected. Therefore, claims that were adjudicated between the aforementioned time periods will be reprocessed and mass adjusted beginning on the June 15, 2004, RA statement.

To Medical Providers:

- Medical claims that have posted EOB 4033 – invalid *procedure code/modifier combination*, 4209 – No *pricing segment on file for the procedure code/modifier billed*, and 4203 – *Denial modifier for non-covered MRO services*, may have been reimbursed incorrectly. The underpayments and potential overpayments issue relating to adjudicated claims posting edit 4033, 4209, and 4203 has been corrected. Therefore, claims that were adjudicated with a modifier in the first, second, or third modifier position that processed between May 25, 2004, and June 4, 2004, will be reprocessed and will appear beginning on the June 15, 2004, RA statement. Mass adjusted claims will begin appearing on the August 17, 2004, RA statement.

To Transportation Providers:

- Transportation providers may have experienced claim payments for HCPCS code *A0130 – non-emergency transport*, where adjudication of the claim resulted in no deduction of the copay amount. The required system change for A0130 to deduct the appropriate copay amount has been completed; therefore claims submitted on or after June 2, 2004, will begin deducting the copay amount. There will not be any reprocessing or mass adjustment of affected claims.
- Transportation claims submitted with procedure code A0130 TT – *Non-emergency transportation; wheelchair van, individualized service provided to more than one patient in same setting (multiple passenger),* for dates of service starting January 1, 2004, may have paid incorrectly up to $20 per unit. Procedure code A0130 TT, which is the replacement for local code Y9201, should be reimbursed at $10 per unit.
  The reimbursement rate was changed from $20 to $10 on June 18, 2004, and the $10 rate will be made retroactive to January 1, 2004. The rate was incorrectly reported in IHCP provider bulletin, *BT200353,* published August 15, 2003. The IHCP will systematically mass adjust all affected claims in the near future and providers will be notified in advance. Most providers will notice only one RA affected by this mass adjustment process. However, some providers may be notified in advance if the process will require additional time.
- Transportation claims submitted with procedure code A0130 – *Non-emergency transportation; wheelchair van*, for dates of service January 1, 2004, through April 15, 2004, may have been paid incorrectly up to $30 per unit. Procedure code A0130, as documented in IHCP provider bulletin *BT200353*, dated August 15, 2003, is to be reimbursed at $20 per unit.
  Affected providers will be notified of the overpayment amount and the number of claim details by letter. The provider notification letter will detail the timeframe for the mass adjustment for the provider's specific claims. The IHCP will systematically mass adjust all affected claims starting June 9, 2004.