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All Providers

2007 Indiana Health Coverage Programs (IHCP) Provider Seminar

An additional session has been added to the 2007 IHCP Provider Seminar, Monday, October 22, 2007. From 8 a.m. to 8:45 a.m. in Salon 3, MDwise will present reimbursement guidelines regarding transportation services. Providers should hand write this session in on the top of the registration form attached to bulletin BT200722 and fax to 317-488-5376 or go online at www.indianamedicaid.com and register online.

Deficit Reduction Act of 2005: Healthcare Common Procedure Coding System and National Drug Code Requirement

Effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) requires all Medicaid providers who submit procedure coded claims for drugs to Indiana Medicaid via the paper UB-04, electronic 837I transaction, and Web interChange, to submit the National Drug Code (NDC), NDC quantity, and the NDC unit of measure. The NDC information is required in addition to the procedure code that corresponds to the drug billed. Claims submitted without the required information will deny. Future provider communications will provide details about this change and related claim submission requirements. The IHCP advanced notification will allow providers sufficient time for business process changes and any related software changes necessary to support this program requirement.

Provider bulletin *BT200713* provided the details about submitting procedure codes with the corresponding NDC information for services billed on the CMS-1500, 837P and Web interChange for professional claims.

Using the 90-Day Provision When a Member Receives Direct Payment from a TPL Carrier

If a provider has proof that an IHCP member received reimbursement from an insurance carrier for provided services, the provider should contact the insurance carrier and advise them that payment was made to the member. The provider should request reimbursement from the third-party carrier. If the provider does not receive reimbursement from the third-party carrier, the provider should document the billing attempts made and submit the claim to the IHCP under the 90-Day provision. The provider should not bill the member.

The 90-Day provision states that when a third-party insurance carrier fails to respond within 90 days of the provider's billing date, the claim can be submitted to the IHCP for payment consideration. However, one of the following must accompany the IHCP claim to substantiate attempts to bill the third party:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Note the date of the billing attempt and the words "**no response after 90 days**" at the top of the claim and attachment. It is imperative that this information is clearly indicated.
- Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days of the provider's billing date.

If a provider receives payment from a third party after the IHCP has paid a claim, the provider must refund the IHCP by submitting a claims adjustment form within 30 days of receipt of the third-party payment.

Providers need to contact the individual managed care organizations (MCOs) for their policy on this issue. Refer to Chapter 5 of the *IHCP Provider Manual* for additional information.

Managed Care Web Page Enhancements

The *Managed Care* section of the Indiana Medicaid Web site has been restructured to provide a more organized and user-friendly interface to view information regarding the managed care programs. The enhancements include the following items:

- New home pages for each of the managed care programs that contain links for program-specific information

- New links for the MCOs' prior authorization and behavioral health information
- A home page for the new program, *Care Select*, which will provide program-specific information as the program is developed

Claims Processing – Use of Place of Service Codes with Claim Submissions

When similar services are rendered to the same member at multiple service locations on a single date of service, it is appropriate to bill the total units on a single line item using a single place of service (POS). Documentation in the medical record must contain the more specific POS for each service rendered.

For example: A community mental health center (CMHC) provides four units of case management services to a member in the office at 10 a.m. on July 10, 2007, and then on the same day provides an additional three units of case management at 3 p.m. in the member's home. The CMHC may bill for seven units of service on one detail of the claim at POS 11 (office) and document in the medical record the number of units rendered at each individual POS.

All providers must follow established policy and coding guidelines for their specialty. Fee-for-service Federally Qualified Health Center (FQHC)/rural health clinic (RHC) providers, should bill only one encounter per IHCP member, per provider, per day unless the diagnosis differs.

Risk-based managed care (RBMC) may have other specific reimbursement guidelines. Providers rendering services in the RBMC delivery system should contact the MCO with whom they are contracted, for information about the billing of multiple service locations.

All Hospice Providers

Change to Hospice Process

Please review this banner page article in conjunction with Section 6 of the *IHCP Hospice Provider Manual* (revision date July 2007) titled *Managed Care Members Electing the IHCP Hospice Benefit.*

Effective October 1, 2007, there will be a change in the process. Health Care Excel (HCE), the Medicaid prior authorization contractor, will be entering the following note for hospice members disenrolled from managed care in the Indiana Prior Authorization (PA) Notice. The notice reads, "Member has been authorized for hospice care for the following service dates: (HCE will specify the service dates). The hospice must fax a properly completed claim form and a copy of this PA notice to the attention of Michelle Stein-Ordonez within the FSSA Division of Aging for reimbursement. The facsimile number is (317) 233-2182."

It will be the responsibility of the hospice to develop internal procedures to ensure that the hospice staff member who receives the PA notice coordinates with the hospice biller for the appropriate claims submission to the FSSA hospice program director. The claims submission should only be for those dates of service specified in the PA notice that are eligible for special batch. The service dates that will be special batched will not necessarily be the service dates of the entire hospice benefit period.

All other procedures as outlined in the current *IHCP Hospice Provider Manual* will remain the same with regard to managed care member's election of hospice services.

Hospice billers with any case-specific questions regarding this special batch process can contact Ms. Stein-Ordonez at (317) 233-1956.

All Optometry Providers

New Technology Intraocular Lenses (NTIOLs)

The IHCP provides additional reimbursement to ambulatory surgical centers (ASCs) and hospitals for outpatient placement of new technology intraocular lenses (NTIOLs). The additional reimbursement is effective July 1, 2006, and covers the cost of the lens and is not included in the ASC rate.

CMS released a new category of NTIOLs. Q1003, *New Technology Intraocular Lens Category 3 (Reduced Spherical Aberration)* is a covered service effective July 1, 2006. The previous categories of NTIOLS Q1001, *New Technology Intraocular Lens, Category I, as defined in Federal Register Notice* and Q1002, *New Technology Intraocular Lens, Category 2, as defined in Federal Register Notice* were end-dated effective December 31, 2005, by CMS.

Facilities must submit claims for the surgical insertion of the NTIOLs using one of the following Current Procedural Terminology (CPT)[1] codes and the appropriate revenue code on a UB-04 claim form:

- 66982, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage*
- 66983, *Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)*
- 66984, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)*
- 66986, *Exchange of intraocular lens*

The NTIOL must be submitted on a separate CMS-1500 claim form using the facilities durable medical equipment (DME) provider number. Q1003 will reimburse at $50 for each implanted lens. The IHCP will reprocess claims that were denied with edit 4021, *Procedure code is not covered for the dates of service for the program billed*. The reprocessed claims will begin appearing on remittance advice (RA) statements dated September 4, 2007.

All Vision Providers

Adjusted HCPCS Codes

The HCPCS codes listed in Table 3 were published with incorrect reimbursement rates and have been corrected. Effective for dates of service on or after January 1, 2006, the amended reimbursement rates for the codes are as follows:

Table 3 – Adjusted HCPCS Codes

Procedure Code	Description	Max Fee Rate	Procedure Code	Description	Max Fee Rate
V2624	Polishing/Resurfacing of Ocular Prosthesis	$45.20	V2627	Scleral Cover Shell	$920.75
V2625	Enlargement of Ocular Prosthesis	$357.94	V2628	Fabrication and Fitting of Ocular Conformer	$225.89
V2626	Reduction of Ocular Prosthesis	$148.13			

Providers must submit adjustments to EDS Adjustments, P.O. Box 7265, Indianapolis, IN 46207-7265 with a copy of this banner page to waive the filing limit.

Contact Information

If you have questions about the articles published in this banner page, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, unless otherwise noted.

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