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All Providers

Annual Seminar

Providers are registering online for the IHCP Provider Seminar scheduled October 22-24, 2007, in Indianapolis. This is to notify you of recent changes to the seminar schedule published in BT200722. Two sessions have been added to introduce the Healthy Indiana Program (HIP). Sessions will take place October 22, 11 a.m. to noon and October 23, 8 a.m. to 8:45 a.m. The Post Payment Auditing session scheduled on October 24 is replaced with an Adjustments session during the same time slot. Providers should not register for the Post Payment Auditing session, but register for the CAR/SUR session instead.

Refer to Table 1 of the BT200722 for session descriptions.

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

If a provider has proof that an Indiana Health Coverage Programs (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.

Annual Update of the International Classification of Diseases

The annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* is effective for the IHCP beginning on October 1, 2007. The new, revised, and discontinued codes may be viewed at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#. To ensure Health Insurance Portability and Accountability Act (HIPAA) compliance, the 90-day grace period will no longer apply to ICD-9-CM updates. Providers must use the appropriate ICD-9-CM diagnosis and procedure codes that are valid for the date of service. Codes not valid for the dates of service will deny. The new ICD-9-CM diagnosis and procedure codes are billable and reimbursable on October 1, 2007. The following new ICD-9-CM diagnosis codes will be added to Table 8.13 *Emergency Department Diagnosis Codes* in the *IHCP Provider Manual*, Chapter 8, Section 2.

Diagnosis Codes Added to Table 8.13 *Emergency Department Diagnosis Codes*

040.41	040.42	058.21	058.29	359.3	414.2	415.12
423.3	440.4	449	488	999.31	999.39	V12.53
V12.54						

Effective September 30, 2007, code 255.4 and code 999.3 are no longer valid and will be removed from the *IHCP Provider Manual*.

The following new ICD-9-CM diagnosis codes will be added to Table 8.65 *High Risk Pregnancy – ICD-9-CM Diagnosis Codes* in the *IHCP Provider Manual*, Chapter 8, Section 3. These codes are effective October 1, 2007.

Diagnosis Codes Added to Table 8.65 *High Risk Pregnancy – ICD-9-CM Diagnosis Codes*

233.30	233.31	233.32	233.39	255.41	255.42	284.81
284.89	359.21	359.22	359.23	359.24	359.29	414.2
415.12	423.3	440.4	449	488	624.01	624.02
624.09	664.60	664.61	664.64	V13.22		

All Dental Providers

Dental Claims Denied for Edits 1008, 231, 232, 1004, 1010, and 7509

Dental claims that were mass adjusted and reprocessed due to retroactive coverage of the annual 2007 Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) changes inadvertently denied for edit 1008, *The rendering provider must have an individual provider*, edit 231 *Rendering provider number is missing*, edit 232 *Rendering physician number not in valid format*, edit 1004, *Rendering provider not eligible to render service on date of service*, edit 1010, *Rendering provider not member of group billing*, and edit 7509 *Rendering provider on prepayment review*.

The affected claims were mass adjusted and reprocessed the week of September 10 and September 17. These claims were denied for dates of service because the Indiana*AIM* system did not require the rendering provider in the *Rendering Provider Number* field. Therefore, claims that were denied for one of these edits with dates of service between January 1, 2007, and April 14, 2007, will be reprocessed with region code 80 and appear on the September 25, 2007, remittance advice.

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.

Hospice Claims – Bill Type 822

The bill type for hospice has not changed since the implementation of the program. The current hospice manual fails to list the specific bill type recognized by Indiana*AIM*. Providers are instructed to submit IHCP hospice claims using bill type 822.

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.

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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