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All Providers

Annual Seminar

Providers are registering online for the Indiana Health Coverage Programs (IHCP) Provider Seminar scheduled October 22 to 24, 2007, in Indianapolis. This is to notify you of recent changes to the seminar schedule published in provider bulletin *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 being replaced with an Adjustment 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 in provider bulletin *BT200722* for session descriptions.

Modifications to Duplicate Logic

For claims and replacements received on or after September 27, 2007, the Indiana*AIM* system duplicate logic has been modified for Medical, Medical Crossover Part B, Outpatient, Outpatient Crossover C, and Home Health claim types. Dental claims have been excluded from this change. The system enhancements are for claim processing to read all five characters of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code, in addition to a HCPCS/CPT code that includes modifiers as part of the procedure (such as 99600 TD-Home Health visit, RN) instead of the first three characters of the procedure code billed.

For example, prior to August 1, 2007, if a claim was billed with procedure code 82550 and procedure code 82552 for the same date of service, the second detail would have suspended for *Edit 5000 possible duplicate* because the first three characters of the procedure code were the same as the first three characters of the procedure code submitted on the first detail. Therefore, the enhancements noted above will allow the system to read all five characters billed and no longer suspend the second detail of the claim for *Edit 5000, possible duplicate.*

Please note that banner page *BR200451* dated December 21, 2004, informed providers that HCPCS codes with the same beginning alpha or numeric characters, for the same member, on the same date of service, and rendered by the same provider required special handling due to claim denials for the exact duplicate edits. As a result of the above modification to duplicate logic in the Indiana*AIM* system, claims submitted with the above criteria will no longer require special handling by the EDS provider field consultant staff or the Written Correspondence Unit. Providers can now submit claims through their normal business process.

Crossover Claims that Previously Denied for Duplicate Edits 5007 and 5008

EDS modified the claims duplicate logic for all crossover claims received on the CMS-1500 claim form. CMS-1500 crossover claims that previously denied for *Edit 5007 exact duplicate header,* and E*dit 5008 suspect dupe header* will no longer deny for these edits. Effective August 1, 2007, crossover claims billed on the CMS-1500 claim form will emulate the possible and exact duplicate logic that is currently applied to medical claims and deny for *Edit 5000 possible duplicate* and *Edit 5001 exact duplicate.*

Tamper-Resistant Prescription Pads Requirements Delay

H.R. 3668, the "TMA, Abstinence Education, and QI Programs Extension Act of 2007," was signed by President Bush September 29, 2007. In part, it establishes a six-month delay for the tamper-resistant prescription pads provisions for Medicaid prescription drugs. Those provisions were set to become effective October 1, 2007. Please refer to banner page *BR200733* and provider bulletin *BT200724* for details. Given the passage of H.R. 3668, the revised effective date for the tamper-resistant prescription pads requirements, as specified in provider bulletin *BT200724*, is April 1, 2008.

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 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 8.14 *Emergency Department Diagnosis Codes* in the *IHCP Provider Manual*, Chapter 8, Section 2.

Diagnosis Codes Added to Table 8.14 *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 CPT/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 Home Health Providers

Home Health Claims Reimbursement

Provider bulletin *BT200716* dated June 26, 2007, announced the rule changes impacting home health rates for State fiscal year (SFY) 2008 and 2009. The rule was signed and was effective July 18, 2007, for SFY 2008 rates. The Office of Medicaid Policy and Planning (OMPP) received approval from the Centers for Medicare and Medicaid Services (CMS) of the State Plan amendment. The new rates are now in the Medicaid system and are effective July 18, 2007. The mass adjustment will occur beginning the week of October 8, 2007, on home health claims with dates of service on or after July 18, 2007.

All Hospice Providers

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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