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All Providers

Coverage of Image-guided Robotic Linear Accelerator Stereotactic Radiosurgery – Healthcare Common Procedure Coding System Codes G0339 and G0340

Effective December 1, 2008, the Indiana Health Coverage Programs (IHCP) began providing coverage of image-guided robotic linear accelerator-based stereotactic radiosurgery (SRS). This service is billable through the Healthcare Common Procedure Coding System (HCPCS) Code G0339 – Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment; and through code G0340 – Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment. Providers that received denials for dates of services on or after December 1, 2008, with error code 520 – Invalid revenue code/ procedure code combination for the HCPCS codes above may resubmit those claims.

UB-04 Paper Claim Form Locator 17 – Patient Status Codes

Table 1 includes the current patient status codes that are valid for UB-04 paper claim forms, form locator 17, as well as upcoming changes. Providers are reminded to refer to the most current edition of the Uniform Billing Editor for proper use of patient status codes.

Note: Patient status code changes are in bold type in Table 1.

Table 1 – UB-04 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
17*	**STATUS** – Enter the code indicating the member discharge status as of the ending service date of the period covered on this bill. **Required for inpatient and long-term care (LTC)**.
Patient Status Codes	
Code	**Description**
01	Discharged to home or self-care, routine discharge
02	Discharged or transferred to another short-term general hospital for inpatient care
03	Discharged or transferred to skilled nursing facility (SNF)
04	Discharged or transferred to an intermediate care facility (ICF)
05	**Discharged or transferred to a designated cancer center or children's hospital. New description effective September 30, 2009, for claims with discharge dates on or after April 1, 2008.**
06	Discharged or transferred to home under care of organized home health services organization
07	Left against medical advice or discontinued care
08	**Discharged or transferred to home under care of a home intravenous provider. Patient status code 08 will be changed from active to inactive effective for claims received on or after September 30, 2009, for claims with discharge dates on or after October 1, 2005.**
20	Expired

30	Still a patient
43	Discharged or transferred to a federal healthcare facility
50	Discharged to hospice – home
51	Discharged to hospice – medical facility
61	Discharged or transferred within this institution to hospital-based Medicare swing bed
62	Discharged or transferred to another rehabilitation facility including discharge planning units of hospital
63	**Discharged or transferred to a long-term care hospital (long-term care facility changed to long-term care hospital), effective for date of receipt September 30, 2009**
64	Discharged or transferred to a nursing facility – Medicaid-certified but not Medicare-certified
65	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (effective April 1, 2004)
66	Discharged or transferred to a critical access hospital (effective January 1, 2006)
70	**Discharged or transferred to another type of healthcare institution not defined elsewhere in code list. Effective September 30, 2009, for claims with discharge dates on or after April 1, 2008. (This was previously the 05 description.)**

Patient Transfers
Special payment policies apply to transfer cases paid using the diagnosis-related group (DRG) methodology. The receiving hospital, or transferee hospital, is reimbursed according to the DRG or level-of-care (LOC) methodology, whichever is applicable. Transferring hospitals are reimbursed a DRG-prorated daily rate for each day, not to exceed the full DRG amount. The Indiana Health Coverage Programs (IHCP) calculates the DRG daily rate by dividing the DRG rate by the average length of stay. The full payment to the transferring hospital is the sum of the DRG daily rate, the capital per diem rate (up to the DRG average length of stay), and the medical education per diem rate (up to the DRG average length of stay). Transferring hospitals are eligible for outlier payments.

To ensure accurate reimbursement, the appropriate discharge status code of 02, 05, 62, 63, 65, 66, and 70 must be placed in the UB-04 form locator 17 on the claim form. (See Table 1 for effective dates.)

Action Required to Access RAs after September 1, 2009

The implementation date for paperless provider communications – September 1, 2009 – is quickly approaching. Be sure to sign up for Web interChange **today**, so you can access your electronic Remittance Advices (RAs). Remember – it takes seven to 10 business days for the Web interChange approval process.

As of September 1, 2009, the IHCP will no longer print and mail provider RAs generated by EDS, banner pages, bulletins, or newsletters (including the Drug Utilization Review Board newsletters). These publications will only be available online.

To keep informed of current communications and policy updates, providers must enroll in the IHCP's E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp. Providers who are already enrolled should verify that their e-mail addresses are correct.

Paper checks that are mailed with the current RAs will continue to be mailed after September 1, 2009, for providers not enrolled in electronic funds transfer (EFT).

Instructions for how to access RAs on Web interChange will be included in the August 2009 provider newsletter.

Claim Correction Forms
Currently, Claim Correction Forms (CCFs) are included with paper RAs. Effective September 1, 2009, the IHCP will no longer print CCFs. Providers can resubmit denied claims with corrections through the existing claims billing process.

For more information, see page 6 of the July provider newsletter NL200907 (The IHCP Implements Paperless Provider Communications) and bulletin BT200912, Implementation of Paperless Provider Communications, dated May 19, 2009.

Quarterly Update to MHQAC Utilization Edits

On June 19, 2007, the Mental Health Quality Advisory Committee's (MHQAC's) recommended utilization edits for mental health medications were implemented (refer to Bulletin BT200709, dated May 3, 2007). The utilization edits are reviewed quarterly, and the additions in Table 2 will be made August 28, 2009:

Table 2 – First-quarter 2009 MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
Venlafaxine HCl 37.5mg tab OSM 24 Oral	1/day
Venlafaxine HCl 75mg tab OSM 24 Oral	2/day
Venlafaxine HCl 150mg tab OSM 24 Oral	1/day
Venlafaxine HCl 225 mg tab OSM 24 Oral	1/day

CMS-1500 Billing Providers

CMS-1500 Medical Paper Claim Submissions for Emergency Services

Effective February 1, 2009, EDS moved to a new scanning system for CMS-1500 paper claim forms. From February 1, 2009, to June 11, 2009, if the emergency indicator (form locator 24C) at the detail level of the claim was marked "Y" (yes) for emergency, the system defaulted the indicator to "N" (no). This may have caused inappropriate claim denials or payments.

For claims that completely denied, EDS requests that providers resubmit paper claim forms that were processed during this time period and that have an emergency indicator of "Y" in field 24 C. If the claim was partially paid or if a copay was inappropriately deducted, please submit a Paid Claim Adjustment form to EDS and state in Box 10, "Emergency Indicator Correction." This will help ensure that paid claim adjustments are processed as expected.

Note: This affected only paper claims; electronically submitted claims were not affected.

Pharmacy Providers and Prescribing Practitioners

Prescription Coverage and Presumptive Eligibility for Pregnant Women

Presumptive Eligibility (PE) for Pregnant Women began July 1, 2009. Women covered under PE will have coverage beginning on the date of PE determination; however, the eligibility verification systems (EVS) take one day to update. It will take as much as two additional business days for information to be passed from the managed care organization (MCO) to the pharmacy benefits managers (PBMs) for each managed care organization.

Women covered under PE will have member identification numbers (RIDs) that begin with the numbers 550 and are 12 digits in length. With the exception of Anthem members, PE members will not receive identification cards from Hoosier Healthwise. The PE determination notice will serve as a form of proof of eligibility. Providers must also check the EVS to verify eligibility and MCO enrollment.

More information about PE, including an example of a PE member approval/acceptance letter, can be found at http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/presumptive-eligibility-(pe).aspx.

Providers are encouraged to advise women with PE coverage to wait two to three days after PE determination before filling prescriptions. If an emergency prescription is needed, the MCOs will work with pharmacy providers to expedite manual transmission of eligibility information to PBMs and pharmacies.

Table 3 indicates each MCO's time line and processes for emergency transmission of eligibility information to PBMs. Women enrolled in fee-for-service will need to wait until the day after PE determination for information to be available in the EDS system that processes pharmacy claims.

Table 3 – MCO Eligibility Timing for PBM

Managed Care Organization (MCO)	Standard PBM Timing	Process for Emergency Prescriptions
Anthem http://www.Anthem.com/ Telephone: 1-866-408-6132	PE information will be in the PBM system two business days after the PE approval.	Call Anthem at 1-866-408-6132.
MDwise http://www.MDwise.org/ Telephone: 1-800-356-1204 In the Indianapolis area: (317) 630-2831	PE information will be in the PBM system by 5 p.m. Eastern Time the second business day after the PE approval.	Call MDwise at 1-800-356-1204. In the Indianapolis area: (317) 630-2831
MHS http://www.managedhealthservices.com/ Telephone: 1-877-647-4848	PE information will be in the PBM system within two days of MHS' receipt of the eligibility file from EDS.	Call MHS at 1-877-647-4848.

Providers of Services to Pregnant Women

Submitting PE Applications for Residents of Marion County

Qualified providers should fax Presumptive Eligibility (PE) applications for members residing in Marion County to the Marion County Division of Family Resources (DFR) located in the Center Township Trustee's (CTT) office at 863 Massachusetts Avenue. The fax number is (317) 232-2038. Please address faxes to the attention of Eric Pangburn or Carol Heckel.

When received, the Hoosier Healthwise applications will be registered in the Indiana Client Eligibility System (ICES). Once an application is registered, an appointment will be scheduled with the client and the appropriate worker, and a notice will be generated and sent to the client.

After the telephone or in-person appointment is completed, the worker will advise the client via the U.S. Mail™ (with a clearly defined deadline for return) about additional verifications needed and how to submit them. If the client happens to submit the verifications to a different office, the receiving office will be able to review the case in ICES, and identify the name and location of the worker assigned to the case. The receiving office can then forward the verifications to the CTT office via fax or U.S. Mail.

Optometrists

Updates to Vision Code Sets

The Common Procedural Terminology (CPT®[1]) codes listed in Table 4 have been removed from the Optometrist Code Set – Provider Specialty 180. These codes fall under the definition of a surgical procedure, as defined by Indiana Code IC 25-22.5-1-1(a), sub-section (C), and are outside the scope of practice for optometrists. The codes are invalid for reimbursement to provider specialty types 180 (optometrists).

Table 4 – Updated Vision Codes

[1] CPT® is a registered trademark of the American Medical Association.

CPT Code	Description
65435	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)
65600	Multiple punctures of anterior cornea (e.g., for corneal erosion, tattoo)
67825	Correction of trichiasis; epilation by other than forceps (e.g., by electrosurgery, cryotherapy, laser surgery)
67938	Removal of embedded foreign body, eyelid
80048 through 89356	Pathology and laboratory procedures, as allowed by provider CLIA certification on file
92230	Fluorescein angioscopy with interpretation and report
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report
92265	Needle oculoelectromygraphy, one or more extraocular muscles, one or both eyes, with interpretation and report

FQHC and RHC Providers

Federally Qualified Health Center and Rural Health Clinic Workshop Scheduled for July 29, 2009

EDS Provider Relations is offering a workshop for Federally Qualified Health Center (FQHC) and rural health center (RHC) providers. There is no cost for the workshop. Participating with EDS will be representatives from the managed care organizations (MCOs) and care management organizations (CMOs) that help administer Care Select. This is an excellent opportunity to become more familiar with Medicaid policies, procedures, and billing specific to FQHCs and RHCs.

Workshops will be presented Wednesday, July 29. Details are below:

Union Hospital
Landsbaum Center, Classroom 3
1433 6½ Street
Terre Haute, IN 47804
Time: 9 a.m. to noon

The agenda includes the following:

- How to check eligibility
- How to file a claim
- How to bill services
- What causes claims to deny
- Avenues to resolve denied claims
- An extensive question-and-answer period

Providers may enroll in the workshop at http://www.indianamedicaid.com by selecting **Provider Services** > **Education Opportunities** > **Workshop Registration**. If you have questions, please call Provider Relations at (317) 488-5072.

Provider Workshops

Third-quarter Workshops

The IHCP is offering quarterly provider workshops free of charge. Topics include Hoosier Healthwise open enrollment; Care Select; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); a managed care and Healthy Indiana Plan (HIP) roundtable; blood lead testing; and Presumptive Eligibility/Notification of Pregnancy. Workshop agendas, dates, registration deadlines, and locations are online at http://provider.indianamedicaid.com/general-provider-services/provider-education/workshop-registration.aspx. You may register online or by using the registration form printed in the IHCP provider newsletter. For more information about the workshops, please contact the workshop line at (317) 488-5072.