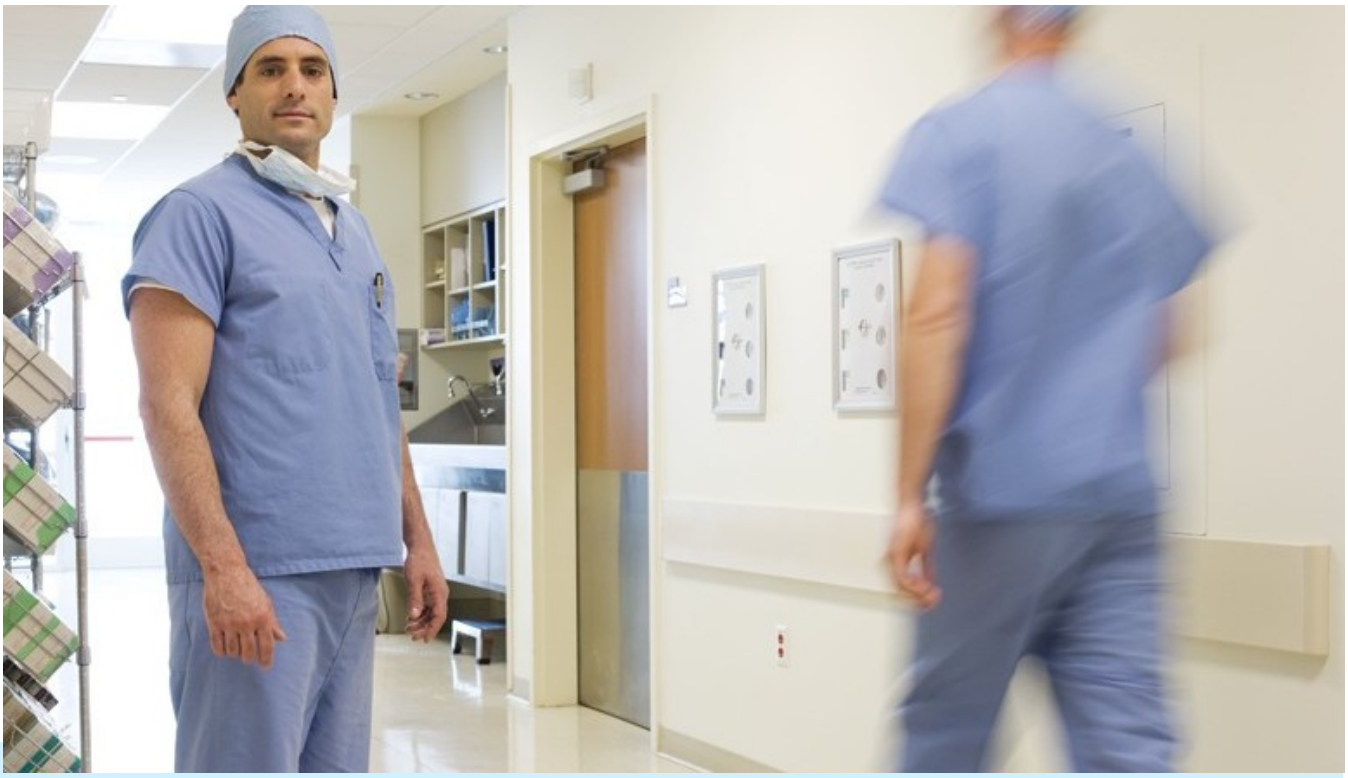
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201139 SEPTEMBER 27, 2011



"Requesting" versus "rendering" provider fields on universal PA form

In January 2011, the Office of Medicaid Policy and Planning (OMPP) required use of a new universal prior authorization (PA) form to submit nonpharmacy PA requests for all IHCP programs. Several of you have requested clarification regarding the "requesting" and "rendering" provider fields on the form.

For Traditional Medicaid and *Care Select*, the requesting provider is the billing entity, and the rendering provider is the individual provider performing the service. If you are a sole proprietor, or a group or corporate business entity, such as a durable medical equipment (DME) supplier or hospital, you must place your billing National Provider Identifier (NPI) or Medicaid Legacy Provider Identifier (LPI) in the "requesting" provider field on the universal PA form. This generates a PA decision letter in Indiana*AIM* that is mailed to the billing or requesting provider's "mail to" address. The "rendering" provider field should contain the NPI or LPI of the physician or other IHCP-enrolled practitioner within the group or corporate business entity who ordered the services, equipment, or supplies. For sole proprietors or dual-status providers, the requesting provider and the rendering provider may be one and the same.

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To ensure that the billing provider receives the PA decision letter from ADVANTAGE Health Solutions℠ (Traditional Medicaid or ADVANTAGE *Care Select*) or MDwise *Care Select*, you must verify that your "mail to" address is updated in Indiana*AIM*. You may update your "mail to" address using the Provider Profile function on Web interChange at indianamedicaid.com. If you do not have "edit" access to update in Provider Profile, contact your Web interChange administrator for that capability. If your Web interChange administrator has not been granted access to the "edit" function, contact HP's Electronic Solutions Help Desk at 1-877-877-5182.

Hoosier Healthwise and Healthy Indiana Plan managed care entities (MCEs) use claims processing systems other than Indiana*AIM*. For this reason, the IHCP recommends that you contact the appropriate MCE (MDwise, Anthem, or MHS) to determine how to use the "requesting" and "rendering" provider fields on the universal PA form.

Home health claims to be mass adjusted

Home health claims with dates of service from July 1, 2011, through September 15, 2011, that did not pay at the new home health rates outlined in BT201145, dated September 1, 2011, will be mass adjusted. Mass adjusted claims will appear on the October 4, 2011, Remittance Advice (RA) and will be identified with internal control numbers (ICNs) that begin with region code 56. If a claim was underpaid, the net difference is paid and reflected on the RA. If a claim was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

Using modifiers for outpatient hospital billing

The Indiana Health Coverage Programs (IHCP) is implementing enhanced code auditing into the claims processing system. This enhanced code auditing supports the Office of Medicaid Policy and Planning's (OMPP's) effort to promote and enforce correct coding efforts for more appropriate and accurate program reimbursement.

Using modifiers with pathology codes

Please note that some pathology codes have both professional and technical components. When submitting claims, use of a modifier depends on whether the entity reporting the service is reporting:

- The professional services of a pathologist only (billed with modifier 26 added to the code)
- The technical component of a laboratory only (billed with the TC modifier added to the code)
- Reporting both the professional and technical components as a global code (billed without any modifier).

In all instances, the first claim received in the system for a particular pathology code on a single date of service is the first one considered for payment. The examples on the next page demonstrate how claims will be considered when more than one claim is received from different providers.

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Claim Example 1 – Same-day laboratory rule – different providers

Claim submitted by hospital

Line Number	From Date	To Date	Revenue Code	Procedure Code	Modifier	Units	Explanation
01	7/15/2011	7/15/201	300	88304	None	1	Detail is allowed

Claim submitted by pathologist/lab

Line Number	From Date	To Date	Revenue Code	Procedure Code	Modifier	Units	Explanation
01	7/15/2011	7/15/2011		88304	26	1	Detail denied with error code 4189

The claim submitted by the hospital did not use a modifier, which indicates it includes both the professional and technical components. The claim submitted by the laboratory used modifier 26, indicating it is for professional services only. The detail on the second claim is denied for error code 4189 – *Multiple units of the same laboratory procedure are not payable for the same date of service, same member and same or different provider without medical necessity*.

Claim Example 2 – Same-day laboratory rule – different providers

Claim submitted by hospital

Line Number	From Date	To Date	Revenue Code	Procedure Code	Modifier	Units	Explanation
01	7/15/2011	7/15/201	300	88304	TC	1	Detail is allowed

Claim submitted by pathologist/lab

Line Number	From Date	To Date	Revenue Code	Procedure Code	Modifier	Units	Explanation
01	7/15/2011	7/15/2011		88304	26	1	Detail is allowed

The claim submitted by the hospital used modifier TC, indicating it is for the technical component only. The claim submitted by the laboratory used modifier 26, indicating it is for professional services only. Both details are allowed.

Procedure code E0784 linked to provider specialty 250 – DME

Effective November 1, 2011, procedure code E0784 – *Osteogenic stimulator, noninvasive, spinal applications* will be linked to provider specialty 250 – *DME (Durable Medical Equipment).* If you are enrolled as Provider Specialty 250, you may bill procedure code E0784 for dates of service on or after November 1, 2011. The provider code sets on indianamedicaid.com will be updated to reflect this provider type and procedure code linkage, effective November 1, 2011.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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