IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201312 MARCH 26, 2013

Use current version of IHCP enrollment forms

On average, 10% of the enrollment forms submitted to the Indiana Health Coverage Programs (IHCP) cannot be approved and are returned to the provider. In many instances, the return occurs because the provider completed an older, outdated version of an enrollment form.

To avoid delay with an enrollment transaction request, the IHCP reminds providers to obtain up-to-date enrollment forms from the Provider Enrollment page at indianamedicaid.com. Because the enrollment forms are updated periodically, only the forms currently posted on the IHCP site should be used when submitting enrollment transactions. Earlier versions of the enrollment forms will not be processed and will be returned to the provider.

CPT code 96376 noncovered effective May 1, 2013

Effective May 1, 2013, the Indiana Health Coverage Programs (IHCP) will no longer cover Current Procedural Terminology (CPT®) code 96376 – *Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility*. CPT code 96376 will be noncovered for dates of service on or after May 1, 2013. Reimbursement for services described by this procedure code is included in the reimbursement rates of other items and services. Code Sets and the Fee Schedule on indianamedicaid.com will be updated to reflect this change.

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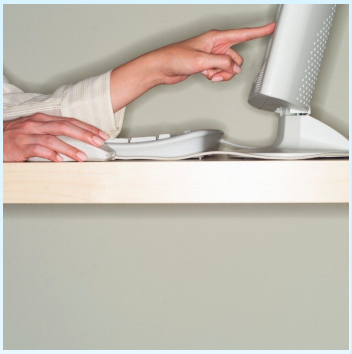
MORE IN THIS ISSUE

Reminder: Balance billing of members is not appropriate

The Indiana Health Coverage Programs (IHCP) reminds providers that it is inappropriate to bill members for any amount in excess of the amount paid by Medicaid for covered services. Further, as a condition of participation in the IHCP, the provider must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or the secondary payer.

Chapter 4, Section 6, of the *IHCP Provider Manual* documents when it is appropriate for a provider to bill the member for noncovered services. An IHCP provider can bill an IHCP member only when the following conditions are met:

- The service must be an IHCP-noncovered service or a covered service for which the member has exceeded the program benefit limitations.
- The member is assigned to the *Qualified Medicare Beneficiary (QMB) Only* or the *Specified Low Income Medicare Beneficiary (SLMB) Only* aid category, and the IHCP pays only the Medicare coinsurance and deductible, but does not reimburse medical coverage.
- Before receiving the service, the IHCP member must be advised that Medicaid does not cover the service and that the member is responsible for the service charges. In this situation, the member must sign a waiver that documents the member's understanding of expected out-of-pocket expenses.



- The provider must maintain documentation in the member's file that the member voluntarily chose to receive the service, knowing that the IHCP does not cover the service.
- The covered or noncovered status of embellishments or enhancements to basic services can be considered separately from the basic service only if a separate procedure code, revenue code, or National Drug Code exists. Only if a separate code exists can a noncovered enhancement be billed to the member and the basic charge billed to the IHCP. Otherwise, the service is considered covered or noncovered in its entirety.
- A provider can bill the member in situations where the provider took appropriate action to ascertain and identify a responsible payer for a service. The provider must maintain documentation to support the member billing and/or show that primary payer information was requested.
- A provider can bill the member if the member failed to advise the provider of Medicaid eligibility within one year from the date of service. The provider must maintain documentation to support the member billing and/or show that primary payer information was requested.
- If the provider is notified of the member's eligibility within the one-year filing limit, the provider must bill the IHCP for the covered service. Under this circumstance, any monies collected by the provider from the member must be reimbursed in full to the member.
- Providers can bill the member the amount credited to the member's spend-down.
- A hospital can bill a member for services if the hospital's utilization review committee established under *42 CFR 482.30* makes a determination that a continued stay is not medically necessary. The determination must comply with the requirements of *42 CFR 482.30(d)*.

Three dental workshops scheduled in April

The Indiana Health Coverage Programs (IHCP) is offering three two-hour workshops for dental providers in April. In the workshop, providers will learn about:

- Using Web interChange to submit dental claims
- Billing and reimbursement for services to Qualified Medicare Beneficiary (QMB) members
- General dental policy
- Member billing and spend-down

The dental workshops are scheduled from 9 –11 a.m. as follows:

- Thursday, April 11, 2013, and Tuesday, April 23, 2013, via Virtual Room
- Thursday, April 18, 2013, at Wishard Hospital in Myers Auditorium at 1001 W 10th Street, Indianapolis

To register for the dental workshops, go to the Provider Education page at indianamedicaid.com.

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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