

# IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS

BR201339

OCTOBER 1, 2013



## ICD-10 changes to paper claims

### 1500 Health Insurance Claim Form (CMS-1500 claim form)

On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised [1500 Health Insurance Claim Form](#) (version 02/12) (CMS-1500 claim form). The Centers for Medicare & Medicaid Services (CMS) announced that it would allow but not require providers to submit claims for Medicare beneficiaries on the revised forms beginning January 6, 2014. The revised form would be required by the CMS for all paper CMS-1500 claim forms submitted on or after April 1, 2014.

The CMS guidance further suggested that all payers should be modifying their paper claim processing to accommodate the revised form sometime between the dates of January 6, 2014, through March 31, 2014.

Following is the Medicare timeline for the transition to the revised CMS-1500 claim form:

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- **January 6, 2014:** Payers begin receiving and processing paper claims submitted on the revised *1500 Health Insurance Claim Form* (version 02/12).
- **January 6, 2014, through March 31, 2014:** Dual-use period during which payers continue to receive and process paper claims submitted on the old *1500 Health Insurance Claim Form* (version 08/05)
- **April 1, 2014:** Payers receive and process paper claims submitted only on the revised *1500 Health Insurance Claim Form* (version 02/12).

*continued*

The Indiana Medicaid implementation details for the *CMS-1500* claim form will be provided in upcoming Indiana Health Coverage Program (IHCP) publications. The notification will include instructions for completing and submitting the form. Figures 1 and 2 illustrate the changes made on the revised *CMS-1500* claim form.

Figure 1 – Item Number 21 from the current *CMS-1500* claim form

Figure 2 – Item Number 21 from the revised *CMS-1500* claim form

On the revised *CMS-1500* claim form, the number of diagnosis code entries expands from four to 12 with no decimals, and the ICD indicator (ICD Ind.) entry field has been added.

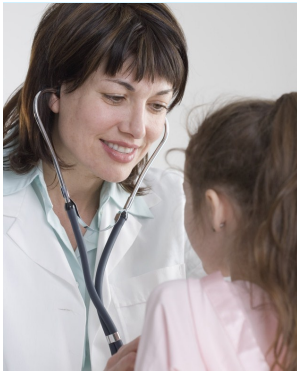
- A valid ICD Ind. value will be "9" for ICD-9 or "0" for ICD-10.
- The fields 21 A-L, once accepted into the system, will be converted to mirror the electronic data interchange (EDI) standards of 1-12, that is, A=1, B=2, C=3, and so on.

### Uniform Billing Form (*UB-04*)

The current version of the Uniform Billing Form (*UB-04*) claim form will continue to be used; however, as shown in Figure 3, Form Locator (FL) 66 will be a required field. Form Locator (FL) 66 is available today, but is not a required field.

Figure 3 – Form Locator (FL) 66 on the *UB-04* claim form

- FL 66 will require a valid ICD version indicator.
- Valid values for FL 66 are "9" for ICD-9 (for dates of service before October 1, 2014), or "0" for ICD-10 (for dates of service on or after ICD-10 implementation on October 1, 2014).



### Age restriction corrected for CPT codes 76885 and 76886

As announced in Indiana Health Coverage Programs (IHCP) banner page [BR201233](#), effective September 26, 2012, changes were made to system logic regarding age restrictions so that IndianaAIM would adjudicate claims based on days, months, and years of age.

The IHCP has determined that the age restrictions for Current Procedural Terminology (CPT®<sup>1</sup>) code 76885 – *Ultrasound, infant hips, real time with imaging documentation: Dynamic (requiring physician or other qualified health care professional manipulation)* and CPT code 76886 – *Ultrasound, infant hips, real time with imaging documentation: Static (requiring physi-*

*cian or other qualified health care professional manipulation)* were redefined incorrectly at that time. The age restrictions for both codes have been corrected in IndianaAIM effective November 1, 2013, to reflect “Members age 0 days – 365 days.”

Claims for CPT codes 76885 and 76886 with dates of service from September 26, 2012, through November 1, 2013, that denied for explanation of benefits (EOB) 4034 – *Procedure code billed not compatible with recipient's age; please verify and resubmit* will be mass adjusted and reprocessed. Adjustments will begin appearing on providers' Remittance Advices (RAs) November 12, 2013, with internal control numbers (ICNs) that begin with region code 56 (mass adjusted) or 80 (mass reprocessed). If the adjustment finds a claim was underpaid, the net difference is paid and reflected on the RA.

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### Maximum fee pricing assigned to CPT code 49083

Effective November 1, 2013, the Indiana Health Coverage Programs (IHCP) has assigned maximum fee pricing to Current Procedural Terminology (CPT) code 49083 – *Abdominal paracentesis (diagnostic or therapeutic) with imaging guidance*. The maximum fee for CPT code 49083 is \$412.39. For dates of service on or after November 1, 2013, the IHCP will reimburse providers billing claims for CPT code 49083 as an outpatient service.

The [Fee Schedule](#) at indianamedicaid.com will be updated to reflect this change.

### Age restrictions for HPV vaccines revised

Effective November 1, 2013, the Indiana Health Coverage Programs (IHCP) is changing the age restrictions for the following Current Procedural Terminology (CPT) codes:

- 90649 – *Human Papilloma Virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use*
- 90650 – *Human Papilloma Virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use*

The current age restriction for CPT code 90649 of ages 9-20 years is being revised to ages 9-26 years for both males and females for dates of service on or after November 1, 2013.

The current age restriction for CPT code 90650 of ages 10-20 years is being revised to ages 9-25 years for females for dates of service on or after November 1, 2013. Please note that CPT code 90650 is restricted to females only.

**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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