IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201411 MARCH 18, 2014

Only revised *CMS-1500* (02/12) claim form accepted as of April 1, 2014

Effective April 1, 2014, the Indiana Health Coverage Programs (IHCP) will accept only the revised version of the *CMS-1500* (02/12) paper claim form. **Paper claims submitted on the current version of the *CMS-1500* (08/05) after March 31, 2014, will not be processed and will be returned to the provider**. The effective date for transition to the new form is based on date of claim submission rather than date of service. For more information and instructions for filling out the revised *CMS-1500* claim form, see *IHCP Bulletin* BT201353.

In addition, ICD indicators are **required** on all *UB-04* and revised *CMS-1500* claim forms. Missing or invalid ICD-10 indicators is one of the top reasons claims cannot be processed and are returned to providers. For more information, see the article below and *IHCP Bulletins* BT201352 and BT201353.

Top two reasons claims are returned to providers: NPI and ICD indicator

The Indiana Health Coverage Programs (IHCP) has identified the top two reasons paper claims are returned to providers: missing or invalid ICD indicator and missing or invalid National Provider Identifier (NPI). Failure to include the necessary information delays processing of your claims.

As a reminder:

- ALL *UB-04* claims ***must*** contain the appropriate ICD indicator in Form Locator field 66.
- All services submitted on the revised *CMS-1500* claim form ***must*** contain the ICD indicator in Form Locator field 21, ICD Ind.
- Valid indicators are **9** for ICD-9 codes and **0** for ICD-10 codes.

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All claims submitted to IHCP, except those submitted by atypical providers, ***must*** contain valid NPIs identifying providers currently enrolled with the IHCP. Claims that do not contain valid NPIs in the appropriate fields will be returned to the provider for correction. To prevent claims from being returned, ensure you have entered the appropriate NPI in the following fields, when applicable.

- *UB-04*
  - Form Locator 56 – Billing Provider NPI
  - Form Locator 76 – Attending Physician NPI
  - Form Locator 77 – Operating Physician NPI (when applicable)
  - Form Locator 78 – Other NPI (when applicable)
- *CMS-1500*
  - Form Locator 17b – Ordering, Prescribing, or Referring (OPR) Physician NPI (when applicable)
    - To be reimbursed, the OPR provider must be enrolled with the IHCP. For more information, see the Ordering, Prescribing, or Referring Providers page at indianamedicaid.com.
  - Form Locator 24J – Rendering Provider NPI (when applicable)
  - Form Locator 33a – Billing Provider NPI

Detailed instructions for completing the NPI fields on the *UB-04* and *CMS-1500* claim forms can be found in *Chapter 8* of the *IHCP Provider Manual* located at indianamedicaid.com.

Reminder – LTC LOC services are covered benefits only under the FFS Traditional Medicaid program

Indiana Health Coverage Programs (IHCP) does not cover Long Term Care (LTC) Level of Care (LOC) services under the Hoosier Healthwise or *Care Select* programs. LTC LOC services are not included in the scope of benefits provided to members in the managed care program. These services are covered benefits under the IHCP fee-for-service (FFS) Traditional Medicaid program only. Managed care members must be **disenrolled** from their health plans before they become eligible for coverage of LTC LOC services. Upon disenrollment from managed care, the member continues **IHCP coverage under the FFS Traditional Medicaid program.**

Member enrollments in managed care programs are effective on the 1st or 15th calendar days of each month. For purposes of care coordination and reimbursement, LTC providers must verify in which IHCP program a new or existing patient is enrolled. Eligibility should be verified upon admission of a new patient, and on the 1st or 15th of the month for existing patients using one of the Eligibility Verification System (EVS) options described in *Chapter 3* of the *IHCP Provider Manual*.

While LTC LOC services are not covered benefits in the managed care delivery system, a managed care plan can provide coverage for members placed in a nursing facility (NF) setting on a short-term basis. Members who require LTC or whose short-term placement becomes a long-term placement must be disenrolled from managed care when LTC LOC is approved and entered into Indiana*AIM*.

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Verification and notification requirements for LTC LOC coverage

The responsibility for verifying patient eligibility and program assignment lies with the NF or LTC facility that has direct access to the patient and the patient's IHCP recipient identification number (RID).

- If the NF or LTC facility determines the patient is enrolled in Hoosier Healthwise or *Care Select* when verifying eligibility (at admission for new patients or on the 1st and the 15th of the month for existing patients approved for LTC LOC services), the NF or LTC facility must notify the managed care plan within 72 hours to facilitate disenrollment from managed care.
- If the NF or LTC facility notifies the managed care plan within 72 hours, the managed care plan shall be liable for charges for up to 60 calendar days from the date of admission until disenrollment occurs.
- If the NF or LTC facility fails to verify a patient's eligibility and managed care assignment or fails to contact the managed care plan within 72 hours, the NF or LTC facility may be at risk for charges incurred until notification is provided.

- In the case of notification after the 72-hour time frame, the managed care plan shall only be liable for charges for up to 60 calendar days from the date of notification. The managed care plan shall have a process that documents the NF or LTC facility's notification.
- If a member with LTC LOC approval is in the NF or LTC facility after 60 calendar days and the member is still enrolled in a managed care program due to lack of notification, the NF or LTC facility becomes liable for any costs associated with the patient until LTC LOC has been implemented.

The 60-calendar-day coverage requirement for the managed care plan is an extension of the current managed care continuity of care policy that requires the health plan that receives the member to honor authorizations of the previous health plan for the first 30 days. This period is intended to allow for the proper notifications and reviews to take place without interrupting the care being delivered to the member. The initial period of 60 calendar days in these cases allows sufficient time for the notification, pre-admission screening, LOC determination, and disenrollment from managed care to take place and ensures appropriate reimbursement to the facility for services rendered.

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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