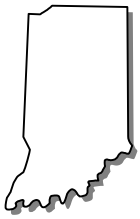
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

B T 2 0 0 3 2 7 M A Y 1 3 , 2 0 0 3

To: All Federally Qualified Health Centers and Rural Health Clinics

Subject: Update in Method of Filing Claims

Overview

This bulletin announces additional codes approved by the Office of Medicaid Policy and Planning (OMPP) meeting the criteria for a valid encounter. The list of additional codes allows claims submitted with Healthcare Common Procedure Coding System (HCPCS) code T1015 to reimburse the rate associated with the provider specific Prospective Payment System (PPS) rate established for billing providers and implemented on April 1, 2003.

Valid Encounter Codes

The following list of Current Procedural Terminology (CPT) and HCPCS codes represents the entire list of procedure codes that Myers and Stauffer LC, in conjunction with the OMPP, has determined to meet the criteria for a valid encounter. As previously stated in Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200318*, the list will be revised on an annual basis.

CPT/HCPCS Codes Meeting the Criteria for a Valid Encounter				
10040	10060	10061	10120	10140
10160	10180	11000	11040	11041
11042	11055	11056	11100	11101
11200	11201	11300	11301	11302
11310	11400	11401	11402	11403
11404	11420	11421	11422	11440
11441	11442	11620	11720	11721
11730	11740	11750	11900	11901
12001	12002	12011	12020	12034
15787	16010	16020	17000	17003
17004	17110	17250	17280	17281
19000	19100	20525	20550	20552

(Continued)

CPT/HCPCS Codes Meeting the Criteria for a Valid Encounter				
20600	20605	20610	20680	23930
26110	29425	29515	29540	29550
29580	30300	30901	31500	31515
31520	32002	32020	36000	36430
36600	36660	38505	39540	45330
46083	46600	46604	46608	54050
56420	56440	56441	56501	56605
57061	57160	57170	57452	57454
57460	57500	57505	57511	57520
58100	58300	58301	59025	59051
59425	59426	59430	59812	62270
62272	64430	64450	69200	69210
69424	76805	76810	90782	90784
90801	90802	90804	90805	90806
90807	90808	90809	90810	90811
90812	90813	90814	90815	90816
90817	90818	90819	90820	90821
90822	90823	90824	90843	90844
90847	92002	92004	92012	92014
92100	92499	92547	92551	92552
92567	92568	93922	93925	93970
93971	94010	94060	94640	94656
94657	94664	94665	94799	95004
95115	95117	97601	97602	97802
97803	98925	98926	98927	98928
99201	99202	99203	99204	99205
99211	99212	99213	99214	99215
99241	99242	99243	99244	99245
99271	99272	99273	99274	99275
99301	99302	99303	99311	99312
99313	99315	99341	99342	99343
99347	99348	99349	99350	99354
99355	99356	99357	99381	99382
99383	99384	99385	99386	99387
99391	99392	99393	99394	99395
99396	99397	99432	99450	99455
99456	99499	W0660	W0661	X3006
59409	98929	76801	76802	

EOB Changes

Due to additional system changes, the following explanation of benefits (EOB) codes have been changed to reflect the verbiage providers will receive with the processing of claims under the PPS reimbursement methodology. For claims submitted with place of service 11, 12, 31, or 72, providers must use both the T1015 encounter code and a valid CPT or HCPCS codes approved by the OMPP. If the claim contains both T1015 and one of the allowable procedure codes from the encounter criteria, and the place of service is other than 11, 12, 31, or 72, the CPT or HCPCS code will deny for EOB *6096* that has been changed to read *The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology*. Additionally, if T1015 is billed with a CPT or HCPCS code that is not on the approved list, the code will deny with EOB 4124, which states, *The CPT/HCPCS code billed is not a valid encounter*.

CMS-1500 Claim Form Completion

Claims submitted with a HCPCS and/or a CPT code on the detail lines should have all applicable information in fields 24A through 24K. When the T1015 code is present on the claim for a place of service 11, 12, 31, or 72, as well as 20 through 26 there should be an allowed amount for those details, or the claim will generate errors for billed amount missing.

Note: Only one encounter per IHCP member, per provider, per day is allowed unless the diagnosis code differs. If a provider renders more than one valid encounter per day with a different diagnosis, or if the place of service differs on the claim, the service must be billed on a separate CMS-1500 claim form. Claims that meet one of the aforementioned scenarios should be forwarded for special handling to the Provider Written Correspondence Unit, P.O. Box 7263, Indianapolis, IN 46207-7263.

Additional Information

Direct questions about the information in this bulletin to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. Direct questions about provider-specific cost reports or rate letters to Myers and Stauffer LC at (317) 846-9521 in the Indianapolis area or 1-800-877-6927.