

Provider WATCH



Important notice regarding code editing

Managed Health Services (MHS) uses code-editing software to help improve the accuracy of its claims processing, payment and reporting. MHS began utilizing an updated version of the code-editing software in October 2009.

The updated code-editing software will ensure that MHS continues to process claims in accordance with generally accepted industry coding in collaboration with Indiana Health Coverage Programs requirements.

Key enhancements include:

- Edits on all outpatient hospital claims to ensure proper coding and billing.
- A tool that bundles certain outpatient hospital services instead of paying line by line. For example, reimbursement will be provided for "lab panels" instead of individual lab services.
- Reimbursement for bilateral procedures that will no longer require a right and left modifier to be billed. Please follow standard bilateral billing practices.
- Explanation of payments that provide increased detail on specific edit reviews.

Most other industry payers are already following the guidelines the new software will provide. The upgrade and the enhancements to the MHS claims process will allow for improved consistency with other payers.

The Clear Claims Tool, the online coding assistant on www.ManagedHealthServices.com, has also been updated. MHS encourages providers to utilize this tool as it is an excellent guide to assist in correct coding of claims. For more information about this notification, call MHS Provider Services at (877) 647-4848.

Present on Admission

In compliance with Indiana Health Coverage Programs' Provider Bulletin BT200928, MHS will follow Centers for Medicare and Medicaid Services (CMS) guidelines that require Present on Admission Indicators (POA) on all qualifying inpatient claims. As outlined within the bulletin, some hospitals are exempt from this requirement. MHS is now required to comply with this requirement for all dates of service after Oct. 1, 2009. Non-compliant claims will be denied. Providers are encouraged to follow the MHS 60-day resubmission timeline.

MHS interpreter services

MHS provides its members with telephonic and face-to-face language assistance for doctor or hospital visits 24 hours a day, 7 days a week, including holidays and weekends. If your office does not have language services for members who speak a language other than English, MHS can help. MHS provides language services in more than 150 languages through the Language Line. MHS can also arrange face-to-face interpreter services for any member if needed.

To schedule telephonic language interpreters through MHS, contact MHS Member Services at (877) 647-4848. To schedule a face-to-face interpreter, contact MHS Member Services at least seven business days before the member's visit so arrangements can be made.

Hearing impaired members can call the Indiana Relay Service at (800) 743-3333. This number can be used anywhere in Indiana. Members should then ask the operator to connect them with MHS at (877) 647-4848

Bariatric Surgery

Effective Jan. 1, 2010, MHS allows benefits for bariatric surgery services only when prior authorization is obtained. MHS prefers the service is performed at facilities that are certified by Centers for Medicare and Medicaid Services (CMS) and American College of Surgeons (ACS) or American Society for Bariatric Surgery (ASBS).

The following Indiana facilities meet these qualifications:

Carmel

Clarian North Medical Center
St. Vincent Carmel Hospital

Fort Wayne

Lutheran Hospital of Indiana Bariatric Center

Gary

Methodist Hospitals Inc.

Indianapolis

St. Francis Hospital and Health Centers

■ Documentation requirements for therapy

MHS reminds physicians of the requirements for therapy in making Prior Authorization requests. MHS will review all requests for occupational therapy, physical therapy, respiratory therapy and speech therapy, within the guidance of 405 IAC 5-22-6. Physicians must ensure that all requests for therapy are made with the following in mind:

- Therapy must be ordered by a physician.
- There must be evidence of physician involvement in the patient evaluation.
- A current plan of treatment with measurable goals must be created.
- If the request is for reauthorization of therapies, then progress notes concerning the member's progress towards previous goals should be included. Maintenance therapies are not covered.
- A current plan of treatment and progress notes that charts the effectiveness of the treatment must be attached to prior authorization requests.
- Therapy must be at a level of complexity and sophistication that matches the condition of the patient based on the judgment, knowledge and skills of a qualified therapist.
- Reimbursement is only available for medically reasonable and necessary therapy.

MHS reminds physicians of the following coverage rules for MHS and other Medicaid patients:

- Maintenance therapy is not covered.
- Therapy for rehabilitative service will be covered for no longer than a period of two years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy.
- Therapy rendered for diversional, recreational, vocational and avocational, for the remediation of learning disabilities or for developmental activities that can be conducted by non-medical personnel is not covered.

MHS requires a physician-ordered, detailed treatment plan and progress notes (as applicable) for all therapy requests. Physicians with questions about the prior authorization requirement for therapies should call MHS Medical Management at (877) 647-4848.

H1N1

In compliance with IHCP requirements, MHS provides coverage for H1N1 when billed with G9141. As a reminder the 99170 series are not covered by the State.

Postpartum Visits

In Chapter 8 of the Indiana Health Coverage Programs (IHCP) manual, the IHCP allows up to two postpartum visits within 60 days after delivery. The IHCP may reimburse the provider for up to two inpatient or outpatient postpartum visits using CPT code 59430, which is for postpartum care only. However, if providers use CPT codes 59410 or 59515, which include delivery plus postpartum care, they can bill one additional postpartum visit using procedure code 59430.

OB Ultrasounds

Effective June 1, 2009, participating providers are no longer required to send authorizations for MHS member OB Ultrasounds. Non-participating providers must get an authorization prior to doing MHS member OB Ultrasounds.

Package B Members

When billing services for a package B member, the claim is not payable if it does not include a pregnancy-related diagnosis code.

Presumptive Eligibility (PE) Members

The Presumptive Eligibility (PE) Provider Manual is available on the IHCP Web site at www.indianamedicaid.com/ihcp/Publications/manuals.htm. The manual includes a listing of ICD9 diagnostic codes that are covered when billing for PE members' services.

Remember: A PE member number will always start with the digits 550. Not all diagnoses or services are eligible for coverage for a PE member.

Credentialing Rights and Responsibilities

Please remember to review your rights and responsibilities for credentialing and recredentialing with MHS. This information is available in the MHS Provider Manual, sent to you following enrollment, and is available at all times on the MHS Web site at www.ManagedHealthServices.com/providers/resources/guides.