

In this issue:

- National Provider Identifier (NPI)
- 1 Paper Claims: Do Not Require National Provider Identifier (NPI)
- 1 Reminder: Physicians and Mid-Levels
- 2 Reminder: Tamper Resistant Prescription Requirements Starts October 1, 2008
- 2 Correction: Vision Providers
- 2 Billing Medicare with HC Referral Numbers
- **2** For Your Information ...
- 3 Clarification of Timely Filing Requirements
- 3 Transition News: Medicaid Management Information System (MMIS)
- 4 Hospital, Outpatient, Professional Providers Billing HCPCS that Require National Drug Codes
- 5 Are You Seeing 002 Explanation of Benefits (EOB) Code on Weekly Remittance Advice?
- 5 Faster Claims Processing: Avoid Billing Duplicate Claims
- 6 Attention Providers: November Regional Workshop Changes
- 7 Global Surgery Policy
- 8 Hurricane Gustav Emergency Provider Enrollment
- 7 Claim Appeals
- 8 October Office Closure

Distributed by the Division of Medicaid Department of Health and Welfare State of Idaho



From the Idaho Department of Health and Welfare, Division of Medicaid

October 2008

National Provider Identifier (NPI)

Are you still getting NPI denial codes on your claims? Your local provider relations consultant (PRC) is available to help you with NPI registrations and claim issues. You can also email your questions to **NPIHD@dhw.idaho.gov**. PRC phone numbers are listed in the sidebar on page 5.

<u>Paper Claims</u>: Do Not Require National Provider Identifier (NPI)

Your NPI is for electronic claims processing. However, paper claims require a valid Idaho Medicaid provider identification number for processing. You can put your NPI on the paper claim, but it is not required. Paper claims are processed using your provider identification number.

Please make sure your provider identification number is in the correct field of the paper claim and is legible for scanning. Remember, a computer will read the claim data so legibility and alignment within the field is very important.

The paper CMS-1500 professional claim form requires a qualifier: **1D** (one-D), to be placed in front of your 9-digit Idaho Medicaid provider identification number in field **33b** (for example: **1D**012345678). It should be legible and aligned within the field. The **1D** qualifier should be entered into field **24I** when a rendering provider's Idaho Medicaid provider identification number is listed in the pink area of field **24J**. Healthy Connections referral provider numbers entered in field **17A** also require a **1D** qualifier proceeding the 9-digit number.

You will find specific instructions for filling out claim forms at the end of Section 3 in your *Medicaid Provider Handbook*.

Reminder: Physicians and Mid-Levels:

You can not bill or represent any service that a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other non-physician professional provides as a **physician** service.

If you bill non-physician services as physician services using the physician's provider identification number, Medicaid can recoup the entire reimbursed amount.

If you have any questions, please contact the Medicaid Fraud and Program Integrity Unit at **prvfraud@dhw.idaho.gov**.

Reminder: Tamper Resistant Prescription Requirements Starts October 1, 2008

Tamper resistant prescription requirements begin October 1, 2008. As of October 1, all fee-for-service Medicaid prescriptions that are either handwritten or printed on paper from an EMR/ePrescribing application must contain at least one feature from each of the three categories of tamper resistance.

For complete information refer to your September 2008 issue of the *MedicAide* newsletter or go to the Health and Welfare Web site at

http://www.healthandwelfare.idaho.gov/site/3355/default.aspx.

Correction: Vision Providers

Starting July 1, 2008, two index lens codes will be covered. Prior authorization is required from the Medical Care Unit. Please indicate if you are requesting glass or plastic index lenses.

HCPCS Code	Description	Idaho Medicaid Criteria
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens	Covered when the participant has a - 4.00 diopter reading or higher
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens	Covered when the participant has a - 10.00 diopter reading or higher

Billing Medicare with HC Referral Numbers

When billing for participants with both Medicare and Medicaid coverage, **do not include an HC referral number** on the claim you bill to Medicare. Doing so might cause Medicare to deny your claim.

If Medicare covers the service, they will process the claim as a *crossover* claim. The HC edits **do not** apply to crossover claims. If Medicare does not cover the service, they will not process the claim as a *crossover* claim. The HC edits **do** apply to non-crossover claims that are subsequently submitted to Medicaid and require the HC referral number on the claim.

Remember, even if the referral number is not required on the claim form, both the primary care physician (PCP) and the provider being referred to must document the specifics of the referral in the participant's file. When the PCP completes a referral form, a copy of the form should reside in the patient's file in both providers' offices.

For Your Information ...

Did you know that the *MedicAide* newsletter can be accessed online at **www.healthandwelfare.idaho.gov**.

Here's how you find it:

- Choose Medicaid Provider Information from the list on the right side of the screen
- Under the Other Resources heading on the right side listing, choose Newsletters
- You can obtain the current newsletter information as well as the archived history

DHW Contact Information

- ◆ DHW Web site www.healthandwelfare. idaho.gov
- ◆ Idaho Careline 2-1-1 Toll free: (800) 926-2588
- Medicaid Fraud and Program Integrity Unit PO Box 83720 Boise, ID 83720-0036 Fax: (208) 334-2026 prvfraud@dhw.idaho.gov

Healthy Connections Regional Health Resources Coordinators

- ◆ Region I Coeur d'Alene (208) 666-6766 (800) 299-6766
- ◆ Region II Lewiston (208) 799-5088 (800) 799-5088
- ◆ Region III Caldwell (208) 455-7244 (208) 642-7006 (800) 494-4133
- ♦ Region IV Boise (208) 334-0717 (208) 334-0718 (800) 354-2574
- ♦ Region V Twin Falls (208) 736-4793 (800) 897-4929
- ◆ Region VI Pocatello (208) 235-2927 (800) 284-7857
- ♦ Region VII Idaho Falls (208) 528-5786 (800) 919-9945
- ♦ In Spanish (en Español) (800) 378-3385

Prior Authorization Contact Information

♦ DME Specialist, Medical Care PO Box 83720

Boise, ID 83720-0036 Phone: (866) 205-7403

(800) 352-6044 (Attn: DME Specialist)

♦ Pharmacy

PO Box 83720 Boise, ID 83720-0036 Phone: (866) 827-9967 (208) 364-1829

Fax: (208) 364-1864

♦ Qualis Health (Telephonic & **Retrospective Reviews)**

10700 Meridian Ave. N. Suite 100

Seattle, WA 98133-9075

Phone: (800) 783-9207 (800) 826-3836 (206) 368-2765

www.qualishealth.org/idaho medicaid.htm

Transportation

 Developmental Disability and Mental Health

Phone: (800) 296-0509, #1172 (208) 287-1172

♦ Other Non-emergent and **Out-of-State**

Phone: (800) 296-0509, #1173 (208) 287-1173

(800) 296-0513 Fax: (208) 334-4979

Ambulance Review

Phone: (800) 362-7648 (208) 287-1157

(800) 359-2236 Fax: (208) 334-5242

Insurance Verification

♦ HMS

PO Box 2894 Boise, ID 83701 Phone: (800) 873-5875

(208) 375-1132 (208) 375-1134 Fax:

Clarification of Timely Filing Requirements

- All claims must be submitted to Idaho Medicaid within 12 months (365 days) from the date of service. If a claim was originally submitted within 12 months of the date of service, a provider is no longer required to provide proof of subsequent continued billing activity in order to have those services considered for payment. Once a service has been billed within 12 months of the date of service, it is considered to have been billed timely. The internal control number (ICN) of the original claim must be documented in the comments field on all electronic or paper resubmissions of the claim in order to prove the timeliness requirement was met. The ICN must indicate that the original claim was submitted within 12 months from the date of service. If the ICN of the original claim is not on the resubmitted claim, the claim will be denied, even if it was originally billed timely.
- If the participant has a third party insurance carrier, the claim for services must be submitted to Idaho Medicaid within 12 months of the date of service regardless of the date of payment or date of the Explanation of Benefits (EOB) from the other insurance carrier. The only exception to this requirement is for Medicare crossover claims. If a claim for payment under Medicare has been filed in a timely manner, Medicaid will consider claims for payment within six months of the Medicaid payment date on the EOB of the Medicare claim.
- Claims for Idaho Medicaid participants receiving retro-eligibility must be submitted within 12 months of the date of service regardless of the date their eligibility was added.
- Idaho Medicaid providers with a retro-active eligibility date must submit claims within 12 months of the date of service regardless of their enrollment date.
- Claims for services requiring prior authorization (PA) from the Idaho Department of Health and Welfare or one of its agents must be submitted within 12 months of the date of service regardless of when the PA was issued.

Providers who fail to bill timely and have their claims denied for this reason cannot pursue collection actions against the participant.

Adjustments to paid claims must be made within two years after the calendar quarter in which the payment was received. Adjustments can only be done on paid claims or paid claim details.

If you have any questions concerning this information, please contact EDS Provider Services at (208) 383-4310 or (800) 685-3757.

Transition News: Medicaid Management Information System (MMIS)

Claims Processing

Idaho Medicaid understands how important it is for providers' claims to pay on the initial submission. We are pleased to announce that there are innovative new features in the upcoming MMIS designed to help you successfully bill claims. One such feature includes:

The ability to modify pending claims. You will be able to log onto the Medicaid Web portal to view and modify any incorrect information on non-finalized claims. For example, you log onto the portal on Monday and see that you have two pending claims, one of which was submitted with the incorrect number of units. You can open the claim, change the units to reflect the correct amount, and resubmit without having to adjust the claim after it is processed.

This is only a sample of the claims processing benefits the new system will provide. Look for next month's article containing more exciting news on changes to come. idahommis@dhw.idaho.gov.

Hospital, Outpatient, Professional Providers Billing HCPCS that Require National Drug Codes

When billing the HCPC (J, Q, and S) codes that require a National Drug Code (NDC) you should first validate that you are using the appropriate code from the most current HCPCS book. Submit NDC information on the NDC Detail Attachment form with the paper claim form, or use electronic billing software that supports this requirement (see Medicaid Information Releases 2003-69 and 2004-07). Collecting NDC information associated with the HCPC code allows Idaho Medicaid to collect rebates due from drug manufacturers, resulting in significant cost savings to Idaho's Medicaid Program. When claims are billed with incorrect NDC information, the drug manufacturers will not pay the state a rebate for drugs dispensed.

Note: You must bill with the actual NDC that was dispensed. You must use the NDC listed on the container from which the drug is dispensed. You can't simply select an NDC from a list, it must be taken from the container or it is considered fraudulent billing.

There have been a significant number of claims with incorrectly billed HCPC or NDC information, which causes lengthy processing delays of the drug rebates due to the state. The most common error is that the NDC data has been converted incorrectly according to the HCPC code being billed.

To avoid billing the incorrect NDC information, the claim data must be entered the same way the information is set up in the State's system. Verify the information through MAVIS, or call your EDS provider relations consultant or provider services representative.

Please verify the following information:

- NDC information on the claim matches the data on the product administered.
- All required fields on the NDC Detail Attachment form are completed, including the NDC, Units and Basis of Measurement.
 - Bill the basis of measurement on the NDC Detail Attachment form either as GR (grams), ML (milliliters), or EA (each). Note that UN (unit) should reflected as EA.
 - The number of units billed for the NDC has been correctly converted based on the HCPC code being billed.

Note: Rarely will the units for the HCPC code be the same as for the NDC, therefore **the conversion step is necessary**.

An example of correct conversion:

- J9201 = Quantity 1 = 200mg
- Units on claim for J9201 = Qty 10 x 200mg (which equals 2,000 mg)
- NDC 00002 7502 01, is dispensed as a vial, the strength is 1 gram (1,000 mg), and the unit of measure is EA.

Therefore, 1 gram/1,000 mg = 1EA

- The Unit Description (Unit of Measure) is EA. Unit of Measure on the NDC Detail Attachment form should be 2EA.
 - This is derived by:
 - Dividing the 2,000 mg of the J Code dispensed by 1,000 mg (1gram) from the NDC description, which calculates to 2 grams.
 - Therefore, 2 grams = 2EA.
 - The NDC Detail Attachment form or the electronic billing screen should then reflect; the NDC of the product dispensed, quantity 2, and unit of measure as EA.

Correct billing practices play a huge part in the benefit to Medicaid from the drug rebate programs and speed claim processing. The Centers for Medicare and Medicaid Services supports the requirement for providers to correctly convert HCPC codes to NDC units for proper billing and rebate retrieval.

EDS Contact Information

◆ MAVIS

Phone: (800) 685-3757 (208) 383-4310

- ◆ EDS Correspondence PO Box 23 Boise, ID 83707
- ◆ Medicaid Claims PO Box 23 Boise, ID 83707
- ◆ PCS & ResHab Claims PO Box 83755 Boise, ID 83707

EDS Fax Numbers

- ◆ Provider Enrollment (208) 395-2198
- ◆ Provider Services (208) 395-2072
- ◆ Participant Assistance Line Toll free: (888) 239-8463

Provider Relations Consultant Contact Information

♦ Region 1

Prudie Teal 1120 Ironwood Dr., Suite 102 Coeur d'Alene, ID 83814

Phone: (208) 666-6859 (866) 899-2512 (208) 666-6856 EDSPRC-Region1@eds.com

♦ Region 2

Darlene Wilkinson 1118 F Street PO Drawer B Lewiston, ID 83501

Phone: (208) 799-4350 Fax: (208) 799-5167 EDSPRC-Region2@eds.com

♦ Region 3

Mary Jeffries 3402 Franklin Caldwell, ID 83605

Phone: (208) 455-7162 Fax: (208) 454-7625 EDSPRC-Region3@eds.com

♦ Region 4

Angela Applegate 1720 Westgate Drive, # A Boise, ID 83704

Phone: (208) 334-0842 Fax: (208) 334-0953 EDSPRC-Region4@eds.com

♦ Region 5

601 Poleline, Suite 3 Twin Falls, ID 83303

Phone: (208) 736-2143 Fax: (208) 678-1263 EDSPRC-Region5@eds.com

♦ Region 6

Abbey Durfee 1070 Hiline Road Pocatello, ID 83201

Phone: (208) 239-6268 Fax: (208) 239-6269 EDSPRC-Region6@eds.com

♦ Region 7

Ellen Kiester 150 Shoup Avenue Idaho Falls, ID 83402

Phone: (208) 528-5728 Fax: (208) 528-5756 EDSPRC-Region7@eds.com

Are You Seeing 002 Explanation of Benefits (EOB) Code on Weekly Remittance Advice?

Does the 002 EOB code appear on your weekly Remittance Advice (RA)?

The 002 EOB code (Provider Name/Number Mismatch) is often reported for paid or denied claims listed on the RA report. This EOB code is informational only, and does not affect claim payment. Claim payment is not denied for this reason code.

Here are some important tips to help prevent reporting of EOB 002 on your RA:

- Review the name in the billing provider portion of your claims.
- Compare that name on the claim with the name in the upper right hand section of your RA. The 002 EOB code indicates that the name on the billing provider portion of your claim does not match the name on file.
- If the RA name is correct, use that provider name on your claims to avoid setting the 002 EOB code.
- To change or correct the name we have on file for your RA to match, please mail or fax a request to:

EDS or Fax to: Provider Enrollment EDS, Provider Enrollment PO Box 23 (208) 395-2198 Boise, ID 83707

Your local provider relations consultant (PRC) can also help review your information for accuracy. Phone numbers for the PRCs are listed in the sidebar on page 5.

Faster Claims Processing: Avoid Billing Duplicate Claims

Duplicate claims comprise the highest volume inventory for all claims that suspend for manual review. This means that a person has to examine the claim to make a decision for payment or denial. Due to the large volume of claims processed, it can take approximately three weeks from the time you bill the service until the decision for payment or denial is reported.

You can decrease the turnaround time from claim submission to payment by not submitting duplicate claims. If we can reduce the total number of claims that suspend because they are duplicates, then we can reduce the average total turnaround time from claim submission to payment.

The information that follows describes billing practices that can decrease the time from claim submission to payment, and therefore increase how quickly we reimburse services.

General Tips

To prevent claims that suspend as duplicates:

- Reconcile your Remittance Advice (RA) and post payments you receive each week so you do not rebill claims that EDS has already paid.
- Wait for claims to appear in the Paid or Denied section of the weekly RA. If the claim is in the Pended section and you submit another claim, it will be a duplicate claim and will also suspend.

Continued on Page 6 (Duplicate Claims)

Continued from Page 5 (Duplicate Claims)

- You can only correct a paid claim with an adjustment. Submit an Adjustment Request Form to correct any errors on paid claims.
- Do not resubmit entire claims with details where some lines have paid and some have denied. Simply resubmit the
 denied lines with corrections. If you resubmit the entire claim without deleting the paid details, the entire claim
 suspends for manual review, which can take up to three weeks. In many cases, when you resubmit just the denied
 lines, the claim does not suspend and payment can be made the week immediately following submission.

Professional Providers – Group Practices

Many providers who offer services enroll as a group practice. These providers share a group provider number for billing purposes. If you submit claims that are paid to the group number, we will include the performing provider services in that payment. If the performing provider resubmits a claim using an individual provider number, the claim will suspend because it has already been paid.

To avoid having claims suspend as duplicates, bill for services with the group provider number and the rendering/performing provider's number, and do not re-bill for services under the performing provider's number. If you originally billed the claim with an incorrect group/performing provider number, you must adjust that claim, not rebill it.

If you have any questions regarding billing with a group number, or how to submit an adjustment, please contact the EDS provider relations consultant in your area or EDS provider services at (800) 685-3757.

Institutional Providers

The following tips apply to institutional providers such as hospitals, hospice, home health, and long-term care: If you are billing for a Rev code that does not require a corresponding CPT code (for example 270, 420, 430, etc.), you must combine all services and bill multiple units for that code on one line. Submitting these charges as separate line items will cause them to be denied as duplicate billings. See the *Medicaid Provider Handbook* for a list of Revenue codes requiring CPT codes.

ASC services are payable once per operating session. For example, procedure 41899, Unlisted Procedure, Dentoalveolar, can only be billed one time per claim. Billing multiple lines on a claim will cause denied lines and delays in your payment.

If you submit the same batch of electronic claims multiple times in a day, immediately contact the EDS EDI department at (800) 685-3757 to prevent the claims from processing the second time.

Processing the batch a second time will result in all the claims suspending as duplicate claims. This increases the inventory of suspended claims and slows processing time for all claims.

When a specific detail on a claim is denied, your claim will process faster if you rebill only the **denied** detail. Resubmitting the entire claim will cause delays in your payment. The most efficient method for rebilling the denied detail is to void the entire claim using an electronic void and submit a claim replacement. This can be done regardless of whether the original claim was paper or electronic.

Attention Providers:

Please note the following changes for the November workshops on your calendars.



- The November workshop for all regions except for Region 5, will be Wednesday,
 November 12 from 2 to 4 p.m. This change is due to the holiday on November 11, 2008.
- The November workshop for Region 5 will be Tuesday, November 4 from 1 to 3 p.m.

Global Surgery Policy

Medicaid follows Medicare's guidelines regarding global surgery policy. If you bill evaluation and management (E&M) procedures within the post-operative days of a surgical procedure, EDS will include them in the payment for the surgical procedure unless you meet the following criteria:

- Your primary diagnosis is unrelated to the surgical diagnosis.
- You submit documentation substantiating that the services rendered were not routine post-operative care.
- The billing or performing providers have different specialized fields of medicine midlevel providers are considered primary care providers.
- You bill the surgical procedure with modifier **54**, and you bill the post-op care with the same surgical procedure and modifier **55**.
- You bill the E&M with modifier 24, indicating the services performed during the post-operative period were not related to the surgery.

Medicaid accepts modifier **24**, regardless of the provider, when an E&M procedure is done during the post-operative care period for reasons that are truly unrelated to the surgical procedure performed. Submit appropriate documentation with the claim and keep it in the participant's file for justification whenever you use this modifier.

Hurricane Gustav Emergency Provider Enrollment

In response to emergencies due to hurricane Gustav, the Louisiana and Mississippi Medicaid Offices are encouraging all medical providers and pharmacies to provide essential services for their Medicaid beneficiaries who may have migrated to your location.

In order to ensure enrollment in their programs, Louisiana and Mississippi have developed emergency enrollment packets for providers in any state willing to serve their temporarily displaced Medicaid beneficiaries. The Emergency Provider Enrollment forms can be obtained through the following Web sites:

- Louisiana: www.lamedicaid.com/provweb1/Gustav/GustavIndex.htm, click on the Emergency Packet for Individual or Emergency Packet for Entity link.
- Mississippi: www.dom.state.ms.us, click on the Emergency Provider Enrollment Form link.

Claim Appeals

To request a review of the reimbursement amount of a particular service, submit a written request to the EDS Correspondence Team. Include the following:

- Provider number.
- Reason you feel you were not properly reimbursed.
- Supporting documentation.

EDS will review the payment amount and send a written explanation if the claim was processed correctly. To appeal EDS' review or request a review of the reimbursement amount of a particular service, send a written request for appeal to the Idaho Department of Health and Welfare (IDHW).

Include the following information with the appeal:

- Copy of EDS' review notice.
- Copy of Adjustment Request form, if applicable. (Do not send an Adjustment Request form if the original claim was denied.)
- Copy of claim and all attachments or a new claim form for possible resubmission.
- Copy of RA.

Medicaid will review the claim and respond in writing with their determination.

Mail appeals to:

Medicaid Claim Appeals Attn: Office of Medicaid Automated Systems (MAS) PO Box 83720 Boise, Idaho 83720-0036 EDS PO BOX 23 BOISE, IDAHO 83707









October Office Closure

The Idaho Department of Health and Welfare and EDS offices will be closed for the following state holiday:

Columbus Day

Monday, October 13, 2008.

A reminder that MAVIS
(the Medicaid Automated Voice Information Service
is available on state holidays at:
(800) 685-3757 (toll-free) or
(208) 383-4310 (Boise local)



MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

Editor: Carolyn Taylor, Division of Medicaid

If you have any comments or suggestions, please send them to:

taylorc3@dhw.idaho.gov

or Carolyn Taylor DHW MAS Unit PO Box 83720 Boise, ID 83720-0036

Fax: (208) 364-1911