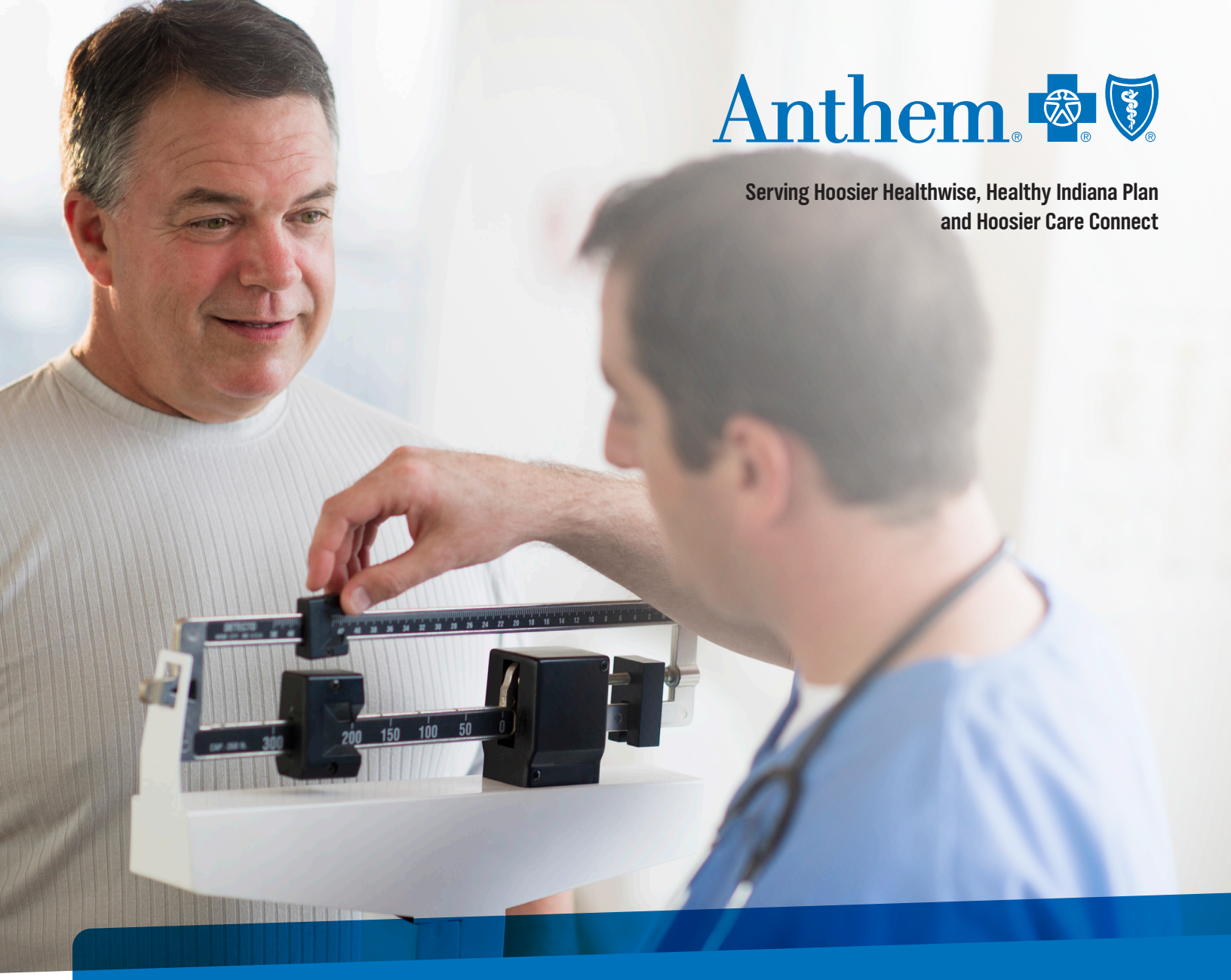

Anthem®

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

Anthem Blue Cross and Blue Shield

Billing:
A Companion Guide to the Indiana Medicaid Provider Manual

For Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

AINPEC-2753-20

Table of Contents

Welcome

Thank you for being part of the Anthem Blue Cross and Blue Shield (Anthem) provider network. At Anthem, we understand that the most important work you do is taking care of your patients. The administrative aspect of medicine is also vitally important, but it shouldn't impede your ability to deliver high-quality health care.

That's why we've created this Companion Guide for Billing Professional, Institutional and Ancillary Claims, divided into three sections. You and your organization play a critical role in managing the care of our members, so we know how important it is to have all the information you need at your fingertips.

If you have any questions about billing or any other topic, you can contact your Network Relations consultant or call Provider Services at the following numbers:

- Hoosier Healthwise — **1-866-408-6132**
- Healthy Indiana Plan — **1-844-533-1995**
- Hoosier Care Connect — **1-844-284-1798**

Section 1: Professional Claims

Providers can depend upon efficient claims handling and faster reimbursement when they follow Anthem's professional billing requirements. These requirements include using standardized codes for most of our health services. This section is broken down into health service categories to help you find the specific billing codes you'll need for each one. You will also find information on the proper method for filling out the *CMS-1500* claim form.

For the most efficient claims processing, accurately filled-out claims are essential. Follow these general guidelines for claims filing:

- Indicate the provider's National Provider Identifier (NPI) number in Box 24J of the CMS-1500 form. Missing or invalid numbers may result in nonpayment.
- Mid-level practitioners should put their NPI number in Box 19 of the CMS-1500 and the supervising Provider's NPI number in Box 24J. The following types of practitioners are defined as mid-level:
  - Physician Assistants
  - Nurse Practitioners
  - Certified Nurse Midwives
- Hoosier Healthwise, Hoosier Care Connect: Use the alpha prefix **YRH** along with the 12-digit Member number provided by the State
- Healthy Indiana Plan: Use the alpha prefix **YRK** along with the 9-digit Member Anthem ID number
- Federally Qualified Health Centers (FQHC) may put their billing/group NPI number in Box 24J and 33.

Coding

In order to process claims in an orderly and consistent manner, we use standardized codes. The Healthcare Common Procedure Coding System (HCPCS), sometimes referred to as National Codes, provides coding for a wide variety of services. There are two principal coding levels, referred to as Level I and Level II:

- **Level I:** Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA). These codes are represented by 5 numeric digits.
- **Level II:** Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and Durable Medical Equipment (DME). These are sometimes called alphanumeric codes because they consist of a single alphabetical letter followed by 4 numeric digits.
- In some cases, 2-digit/character modifier codes should accompany the Level I or Level II coding.

There are two useful reference guides for coding claims:

- The Current Procedural Terminology (CPT) manual, published by the American Medical Association. To order, call **1-800-621-8335**.
- The Healthcare Common Procedure Coding System (HCPCS) published by the Centers for Medicare & Medicaid Services (CMS). To order, call **1-800-621-8335**.

Anthem does not accept global billing codes. If Anthem receives a claim with global coding, it will be denied requesting a corrected claim be submitted using itemized codes.

National Drug Codes

Providers must include **National Drug Codes** (NDCs), **Unit of Measurement** and **Quantity of Drug** on all claims that include physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings. The NDC is an 11-digit number on the package or container from which medication is administered.

The Family and Social Services Administration (FSSA) requires that Anthem report the National Drug Code information to the FSSA every month. Anthem will deny professional and outpatient institutional claims containing physician-administered drugs if any of the following elements are missing or invalid:

- NDCs
- Unit of Measurement
- Quantity of Drug

Providers should follow instructions outlined in the **Claims and Billing Procedures Modules** in the *IHCP Provider Reference Modules.* To determine which procedure codes require the inclusion of an NDC, providers may access the Codes Sets page at **www.in.gov/medicaid/providers/693.htm**. Select Launch Provider Code, click "Accept", then choose Procedure Codes That Require NDCs.

Initial Health Assessments

Anthem primary medical providers function as a member's "medical home." For that reason, we strongly recommend that an initial health assessment (IHA) consisting of a complete history and physical and preventive services be conducted within the first 90 days of enrollment. When billing for initial health assessments, use the following International Classification of Diseases (ICD) diagnosis codes:

- Z00.121-Z00.129 for children (newborn to 20 years old)
- Z00.00-Z00.01 for adults (19 years and older)

The member can also complete the Health Needs Screening and receive an incentive online at **www.anthem.com/hns** or over the phone by calling **1-866-408-6131** for Hoosier Healthwise and Healthy Indiana Plan or **1-844-284-1797** for Hoosier Care Connect.

Preventive Medicine Services: New Patient

Preventive medicine services for a new patient start with an initial comprehensive preventive medicine evaluation. That includes an age and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures. Bill for these services using the following codes:

Code	Description
99381	Infant (Under 1 Year)
99382	Early Childhood (Ages 1-4)
99383	Late Childhood (Ages 5-11)
99384	Adolescent (Ages 12-17)
99385	Ages 18-39
99386	Ages 40-64
99387	Age 65 and older

Preventive Medicine Services: Established Patient

Preventive medicine services for an established patient involve re-evaluation and management of existing conditions, if any. That includes an age and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures.

Code	Description
99391	Infant (Under 1 Year)
99392	Early Childhood (Ages 1-4)
99393	Late Childhood (Ages 5-11)
99394	Adolescent (Ages 12-17)
99395	Ages 18-39
99396	Ages 40-64
99397	Ages 65 and older

Self-Referable Services

Members may access the following services at any time without pre-authorization or referral by their primary medical provider:

- Behavioral Health Services (Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect)
  - Psychiatric Services: Anthem members may self-refer to any IHCP-enrolled behavioral health services psychiatrist.
  - Behavioral Health Services **not** rendered by a psychiatrist: Anthem members may self-refer to any in-network Behavioral Health Services provider, including behavioral health, substance abuse and chemical dependency
- Chiropractic Services (Hoosier Healthwise, HIP Maternity, HIP Plus, HIP members with State Plan Benefits, Hoosier Care Connect)
- Diabetes Self-Care Training (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)
- Emergency Services (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)
- Eye and Vision Care, except surgery (Hoosier Healthwise, HIP Plus, HIP Maternity, HIP Basic members ages 19 and 20 or pregnant, and HIP members with State Plan Benefits, Hoosier Care Connect)
- Family Planning (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)
- Podiatry (routine foot care is not covered for Hoosier Healthwise Package C)
- Vaccines (Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)

Behavioral Health

Anthem has contracted with a network of hospitals, group practices and independent behavioral health providers, as well as a number of Indiana's Community Mental Health Centers (CMHCs) to provide behavioral health services. Providers rendering medically necessary behavioral health services should bill Anthem using behavioral health CPT codes.

Emergency and Related Professional Services

Emergency services, as defined by state and local law, the provider contract and our *Member Handbook*, are reimbursed in accordance with the Anthem provider contract. Authorizations are not required for medically necessary emergency services.

Emergency: Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

- Place the member's health or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy
- Cause serious impairment to bodily functions
- Cause serious dysfunction to any bodily organ or part

Covered Emergency Services include:

- Hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize the emergency medical or behavioral health condition
- Services by emergency providers

Emergency Services Copayment
If a member receives treatment in a hospital emergency room for a nonemergent condition, a copayment of $8 for HIP members and $3 for Hoosier Care Connect is required. Members are not required to pay the copay if they call Anthem's 24/7 NurseLine first and are advised to go to the ER. For HIP members, POWER Account funds cannot be used by the member to pay the copayment.

The copayment requirement will be waived according to prudent layperson guidelines. If Anthem determines through the claims process that the copayment should not have been charged, and the hospital collected a copayment, you must refund the copayment to the member.

Providers shall not collect copayments for emergency room visits resulting in an inpatient admission. Related professional services offered by providers during an emergency room visit are reimbursed according to your Anthem provider contract.

Assuming the member has an available and accessible non-emergency services provider, and a determination has been made that the member does not have an emergent condition, the hospital must inform the member before providing nonemergency services of the following:

- The hospital may require a copayment before the service can be provided
- The hospital will provide the name and location of an alternate non-emergency services provider who is actually available and accessible
- An alternate provider can provide the services without a copayment
- The hospital will provide a referral to coordinate scheduling of services

All members should be referred back to their primary medical provider for follow-up care. Unless clinically required, follow-up care should never occur in a hospital emergency room.
Hospitals will be reimbursed for emergency services billed with codes: **99284, 99285**

Hospitals may only bill **Revenue Code 451** if the emergency room screening determines that the visit is nonemergent. Hospital reimbursement will be reduced by 40% for services billed with codes: **99281, 99282 and 99283**

Vaccines for Children

Immunizations Covered

Anthem network providers who administer vaccines to children 0-18 years of age may enroll in the Vaccines for Children (VFC) program, which provides free vaccine products to providers. Anthem will only reimburse the administration fee – limited to the lesser of the billed amount or $15, unless otherwise identified in the provider contract – for any vaccine available through the VFC program. Correct billing includes:

- ICD-10 routine child health check code (see Z00.121, Z00.129) as the primary diagnosis code, with the applicable vaccine ICD-10 code in the secondary, tertiary or other position.
- Specific vaccine or combination vaccine administered by using the appropriate vaccine product procedure code with a billed amount of $0.
- Vaccine administration code with modifier SL as the first modifier. Other applicable modifiers would be appended after the SL.
    - 90471 SL: Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); one vaccine (single or combination vaccine/toxoid); VFC vaccine administration
    - 90472 SL: Each additional vaccine (single or combination vaccine/toxoid); VFC vaccine administration
    - 90473 SL: Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid); VFC vaccine administration
    - 90474 SL: Each additional vaccine by intranasal or oral route (single or combination vaccine/toxoid); VFC vaccine administration

Use the CMS-1500 form:

- On one line of Box 24D, use the appropriate CPT code
- On another line of Box 24D, use the appropriate administration procedure code
- In Box 23, insert the primary medical provider name

Immunizations Not Covered

The IHCP allows separate reimbursement for the vaccine product and administration fee for vaccines that are not part of the VFC program. Providers should report these services following the billing guidelines above, except:

- Use the appropriate ICD-10 for the encounter.
- Report the specific vaccine or combination vaccine administered by using the appropriate vaccine product procedure code with your usual and customary charge.

Use the CMS-1500 form:

- On one line of Box 24D, use the appropriate CPT code
- On another line of Box 24D, use the appropriate administration procedure code
- The SL modifier is not required

Additional Services during EPSDT Exams

If a patient is evaluated and treated for a problem during the same visit as an EPSDT annual exam or well-child visit, the problem-oriented exam can be billed separately if accompanied by the 25 modifier. The problem must require additional moderate level evaluation to qualify as a separate service on the same date.

Maternity Services

Maternity services are covered by the Healthy Indiana Plan (HIP) through the HIP Maternity plan. There are no copays for maternity services and once a member is verified to be pregnant, she will have no copays for any services, and no POWER Account contribution. Maternity services also continue to be a covered benefit for Hoosier Healthwise and Hoosier Care Connect. Please refer to the IHCP Reference Modules for detailed instructions. You can access the state's reference modules at **https://www.in.gov/medicaid/providers/469.htm**.

Anthem requires itemization of maternity services when submitting claims for reimbursement. Please use the *CMS-1500* claim form with the appropriate CPT and HCPCS codes, along with ICD diagnosis codes. This includes the applicable evaluation and management (E&M) code, along with coding for all other procedures performed. Maternity billing guidelines are as follows:

- Anthem reimburses only one delivery or cesarean section procedure per member in a 7-month period. Reimbursement includes multiple births.
- Delivering providers who perform regional anesthesia or nerve block may not receive additional reimbursement because these charges are included in the reimbursement for the delivery.
- Anthem reimburses anesthesia services and delivery at full allowance when provided by the delivering obstetrician.
- Anthem will reimburse antepartum care, deliveries including cesarean sections performed by physicians, and postpartum care:
    - **Codes 59409, 59514, 59612** and **59620**: Vaginal and Cesarean Deliveries
    - **Code 59430**: Postpartum care only (if in the inpatient setting within 21 days following delivery, the claim will deny unless submitted with medical records documenting the patient received services represented by this code as recommended by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics)
    - **Code 59425**: Antepartum care only (2-6 visits)
    - **Code 59426**: Antepartum care only (7 or more visits)
- When billing Anthem, you must itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted.
- Providers must bill the procedure code for the visit in conjunction with the appropriate U1, U2, or U3 modifier to identify prenatal visits in each trimester for each specific date of service:
    - U1 – Trimester one – 0 through 14 weeks, 0 days
    - U2 – Trimester two – 14 weeks, 1 day through 28 weeks, 0 days
    - U3 – Trimester three – 28 weeks, 1 day through delivery
- Laboratory (including pregnancy test) and radiology services provided during pregnancy must be billed separately and be received by Anthem within 90 days from the date of service.
- Use of the appropriate antepartum or postpartum CPT codes is necessary for appropriate reimbursement. You should indicate the estimated date of confinement (EDC) on the *CMS-1500* claim form.
- If a member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.
- If high risk, the high-risk diagnosis must be documented on the claim form.
- The nature of a high-risk care visit must be identified in the diagnosis field on the *CMS-1500* claim form, or the appropriate field.
- For professional claims only, the date of the member's last menstrual period must be included.

Claims for Obstetric Deliveries Require a Modifier
Deliveries performed prior to 39 weeks and zero days will be covered only when certain approved, medically necessary indications, including spontaneous early labor/delivery, are present and documented. One of the following modifiers will be required on the CMS-1500 claim form when billing with CPT codes 59409, 59514, 59612 and 59620. CPT delivery codes 59410, 59515, 59614 and 59622 are not covered.

- UA: Nonmedically necessary deliveries prior to 39 weeks, zero days of gestation; if the delivery does not meet the IHCP's stated guidelines for approved medically necessary deliveries (please refer to **Obstetrical and Gynecological Services** in the IHCP Provider References Modules for approved conditions), *the claim will automatically deny.* The right to appeal is retained.
- UB: Medically necessary deliveries prior to 39 weeks, zero days; deliveries resulting from spontaneous labor/delivery or inductions or cesarean sections with a documented IHCP-approved medical indication (please refer to IHCP Bulletin BT 201421 for approved indications).
    - Claims with the UB modifier **and** one of the diagnosis codes on the *Medical Necessity Code List* will pay (you may find this list at **www.anthem.com/inmedicaiddoc** > **Prior Authorization & Claims** > **Prior Authorization > Forms and other resources**).
    - If a claim is submitted with the UB modifier but without a code from the *Medical Necessity Code List*, medical records demonstrating medical necessity for delivery must be submitted with the claim. Please verify that diagnosis codes indicating spontaneous labor prior to 39 weeks, zero days are included. Submitted medical records will be reviewed prior to payment to determine if the delivery was medically necessary and the claim will pay or deny accordingly. In the case of denial, the provider retains the right to appeal.
    - If a claim is submitted with the UB modifier but there is no diagnosis code on the claim from the *Medical Necessity Code List*, and no records are submitted with the claim, the claim will deny. The provider will have the right to appeal and may submit medical records at that time.
- UC: Deliveries at 39 weeks, zero days of gestation or later, regardless of method (induction, cesarean section or spontaneous labor); *these claims will automatically pay.*

Cesarean Sections
Medicaid restricts any Cesarean section, labor induction, or any delivery following labor induction to one of the following additional criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks or fetal lung maturity must be established before delivery.
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery.

Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary will be denied. Records will be subject to retrospective review. Payments made for non-medically-indicated Cesarean section, labor induction, or any delivery following labor induction that fails to meet these criteria, (as determined by review of medical documentation) will be subject to claim recoupment. Recoupment may apply to all services related to the delivery, including additional provider and hospital fees.

Newborns
Submit newborn claims to Anthem for Hoosier Healthwise using the state-issued Medicaid ID number of the newborn. Do **not** use the temporary ID numbers (those ending with NB followed by one or more digits). Anthem rejects claims with temporary ID numbers.

You will also need to submit the name, date of birth and other pertinent information about the newborn. To prevent any lapse in Anthem coverage for newborns, please ask your patients to take these important steps as soon as their babies are born:

- Immediately contact the Indiana Family and Social Services Administration (FSSA) or their social worker to request the required paperwork
- Fill out and return the required paperwork to the state to enroll their newborn in Medicaid
- Anthem requests that you notify us of all deliveries **within three days of delivery**. Use the *Newborn Enrollment Notification Report* found on our website at **www.anthem.com/inmedicaiddoc** under **Provider Support > Helping Members > Maternal Services.**
- Also notify Anthem via the *Newborn Enrollment Notification Report* referenced above when you receive a newborn's permanent Medicaid ID number.

Hospitals may bill for newborn delivery and other newborn services separately from the claims for services they provide for the mother.

Circumcision

All circumcisions performed on members more than 30 days after birth will require authorization from the plan's Utilization Management department and will be subject to medical necessity.

On-Call Services

On-call services can be billed when the rendering physician is not the primary medical provider, but is covering for or has received permission from the primary medical provider to provide service that day. Insert **On-Call** for primary medical provider on the *CMS-1500* claim form.

Sterilization and Hysterectomy

Sterilization and hysterectomy procedures must comply with federal rules and regulations noted in 42 CFR 441.250-441.259 and 405 IAC 5-28-8 and 405 IAC 5-28-9.

Sterilizations
Sterilization renders a person unable to reproduce. Anthem reimburses for sterilizations when the consent form accompanies all claims connected with the service for men and women according to 405 IAC 5-28-8. Providers must note partial sterilization on the face of the claim form, preferably on the line below the HCPCS procedure code. For sterilizations performed at the time of delivery, providers must bill with a 59 modifier.

A sterilization form is not necessary when a provider renders a patient sterile as a result of an illness or injury. The physician must attach a certification to the claim indicating that the sterilization occurred due to an illness or injury when prior acknowledgement was not possible. The provider must also include a description of the nature of the emergency.

Limitations
Anthem may reimburse for the sterilization of an individual only if that individual meets the following requirements:

- Is 21 years old or over at the time the informed consent is given, 42 CFR 441.253
- Is neither mentally incompetent nor institutionalized, 42 CFR 441.251
- Has voluntarily given informed consent, 42 CFR 441.257 through 441.258

For claims submitted with the procedure codes and diagnosis codes shown in Table 8.182, the IHCP suspends the claims for an analyst to review the consent form or documentation of partial sterilization.

Procedure Codes That Suspend for Analyst Review of Consent Form

Procedure Code	Description
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral
55250	Vasectomy, unilateral or bilateral (separate procedure) including postoperative semen examination(s)
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
58570*	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less
58571*	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
58572*	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g
58573*	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean section or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
A4264	Miscellaneous DME supply, accessory and/or service component of another HCPCS code

***Requires an Acknowledgement of Receipt of Hysterectomy Form with the claims.**

Hysteroscopic sterilizations with an implant device provide a non-incision permanent sterilization option. Anthem covers this procedure for eligible female members 21 years old and older. This procedure can be performed in the office, as an outpatient, or in an ambulatory surgical center (ASC). Providers should bill the procedure using Current Procedural Terminology (CPT) code 58565 – Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants. However, CPT code 58579 – Unlisted hysteroscopy procedure, uterus is not appropriate billing for the hysteroscopic sterilization procedure with an implant device, and claims will suspend for manual review.

The implant device must be billed separately on the *CMS-1500* claim form using HCPCS code A4264 – Miscellaneous DME supply, accessory and/or service component of another HCPCS code. This is the only code billable for the implant device.

An outpatient hospital or ASC must adhere to the following billing instructions to receive reimbursement for the implant device in addition to the outpatient ASC rate. No additional reimbursement is available for the implant device if performed in an inpatient setting. Table 8.183 provides billing instructions for these services.

Billing Instructions for the Hysteroscopic Sterilization Procedure with Implant Device

Provider	Claim Type	Bill for the Procedure and the Supply	Additional Billing Requirements
Outpatient Hospital or ASC	UB-04	58565 with appropriate revenue code	Print the name of the implant device in the body of the claim form or on the accompanying invoice Submit a valid, signed Sterilization Consent Form with the claim Enter ICD Z30.2 – Encounter for Sterilization as the primary diagnosis on the claim
	CMS-1500 bill for the device under the professional or durable medical equipment (DME) provider number	Bill the device using A4264 – Include a cost invoice with the claim to support the actual cost of the device	
Physician	CMS-1500	58565	
		Bill the device on a separate line using A4264 – Include a cost invoice	

Providers must adhere to the following procedures:

- Submit the manufacturer suggested retail price (MSRP) with the claim to support the cost of the device. The IHCP reimburses 75% of the amount listed on the manufacturer's cost invoice up to a statewide maximum of $1,700.
- Submit a valid, signed Sterilization Consent Form with the claim.
- Ensure the primary diagnosis on the claim is ICD code Z30.2 – Encounter for Sterilization.
- Print **"Sterilization Implant Device"** on the claim form or on the accompanying invoice.

Informed Consent

Providers must allow at least 30 days, but not more than 180 days, to pass between the date when the member gives the informed consent, and the date when the provider performs the sterilization procedure.

The patient must give the informed consent at least 30 days before the expected date of delivery or confinement. The Indiana Health Coverage Programs (IHCP) defines premature delivery as labor before 37 weeks' gestation. The following exceptions apply to premature delivery or emergency abdominal surgery:

- The member must sign the informed consent for the sterilization for family planning 72 hours before the sterilization when done at the time of a premature delivery.

- The physician must indicate the reason for the surgery being performed early and the individual's expected date of delivery. The reason for the surgery must be only because of premature delivery or emergency abdominal surgery.
- The person who obtains informed consent must verbally communicate all information about a sterilization procedure to the member to be sterilized, including a member who is blind, deaf or otherwise handicapped. Providers must furnish an interpreter if a language barrier exists. For a full description of the informed-consent process, 42 CFR 441.257 provides additional information.

Providers cannot obtain informed consent while the member to be sterilized is in one of the following situations:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substances that affect the member's state of awareness

Retroactive Eligibility or Failure to Provide Proof of Eligibility

If the provider does not obtain the required State sterilization consent form before the procedure because of a retroactive eligibility situation or because the patient failed to inform the provider of IHCP eligibility, the IHCP does not cover the service. Anthem or Medicaid cannot pay for sterilizations performed if the member did not sign the consent form before the procedure. The provider cannot bill the member for the procedure if there was no consent signed prior to the procedure. To prevent this situation and to ensure IHCP coverage, providers may use the State consent form for sterilization notification for all Medicaid patients in their practice. Other nonsterilization procedures may be separately billable.

If unrelated services are provided at the same time as sterilization for an Anthem member, the provider can be reimbursed for medically necessary services unrelated to the sterilization when the sterilization is noncovered due to consent not being obtained. Medically necessary services are subject to the IHCP's established policy on retroactive services as outlined in the **Member Eligibility and Benefits Modules** in the *IHCP Provider Reference Modules*.

Consent Forms

A properly completed Consent for Sterilization form, online at the U.S. Department of Health and Human Services at **https://opa.hhs.gov/sites/default/files/2020-07/consent-for-sterilization-english-updated.pdf**, must accompany all claims for voluntary sterilization. When providers properly complete the Consent for Sterilization form (HHS-687), Anthem receives all the necessary information regarding consent, interpreter's statement, statement of person obtaining consent and physician's statement. A Spanish version of the form is also available online at **https://opa.hhs.gov/sites/default/files/2020-07/consent-for-sterilization-spanish-updated.pdf**.

Documentation Requirements

A completed consent form must accompany all claims for sterilization and related services. This requirement extends to all providers: attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, or other providers of related services. Providers must attach a photocopy of the consent form for sterilization and related services to each claim form or send it separately as an attachment to the electronic claim transaction.

Anthem must receive a properly completed consent form before making payment. To ensure timely payment to related service providers, the primary service provider should forward **exact** copies of the properly completed consent form to the related service providers.

Hysterectomy Billing
The IHCP provides coverage for a medically necessary hysterectomy performed to treat an illness or injury. The IHCP does not cover a hysterectomy performed solely to render a member permanently incapable of bearing children, whether performed as a primary or secondary procedure.

Informed Consent and Acknowledgement Statement
The IHCP covers hysterectomy only when medically necessary, and only when the member has given informed consent. The provider must have informed the member orally and in writing that the procedure will render the member permanently incapable of reproducing, and the member must have signed a written acknowledgement of receipt of that information.

The member or member's representative must sign an informed consent or acknowledgement except when the patient is already sterile, or a life-threatening emergency exists for which the physician determines prior acknowledgement is not possible. However, the physician who performs the hysterectomy under these circumstances must complete the following requirements:

- Certify in writing the individual was already sterile at the time the hysterectomy was performed.
- State the cause of the sterility at the time of the hysterectomy.
- Certify in writing that the hysterectomy was performed under a life-threatening emergency in which the physician determined that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

Claims billed with the procedure codes for hysterectomy shown in the following table require a document that includes the information necessary to satisfy documentation and certification requirements for hysterectomies. **Providers cannot use the sterilization consent form for hysterectomy procedures under any circumstances. Please use the Acknowledgement of Receipt of Hysterectomy Form with the claims.**

Procedure Codes – Hysterectomy Services
Refer to **Obstetrical and Gynecological Services** in the IHCP Provider References Modules for more information.

00846	00944	01962	01963	01969	45126	51597	51925	58150	58152	58180
58200	58210	58240	58260	58262	58263	58267	58270	58275	58280	58285
58290	58291	58292	58293	58294	58541	58542	58543	58544	58548	58550
58552	58553	58554	58570	58571	58572	58573	58951	58953	58954	58956
59135	59525									

Providers must attach the appropriate documentation to the paper claim form or send it separately as an attachment to the electronic claim transaction. All providers of hysterectomy-related services must attach a photocopy of the appropriate acknowledgement or physician certification to the claim. The primary service provider should forward copies of the acknowledgement or physician certification statement to the related service providers to ensure timely payment.

Retroactive Eligibility
Retroactive eligibility rules parallel those noted above according to 42 CFR 441.255. The IHCP pays for hysterectomies performed during an individual's retroactive eligibility if the physician who performed the hysterectomy certifies the following in writing:

- The physician informed the individual before the operation that the hysterectomy would make her permanently incapable of reproducing.
- The individual was already sterile before the hysterectomy.
- The individual required a hysterectomy because of a life-threatening emergency. The physician determined that prior acknowledgement was not possible, and the physician who performed the hysterectomy did one of the following:
    - Certified in writing that the individual was already sterile at the time of the hysterectomy, and stated the cause of the sterility.
    - Certified in writing that the hysterectomy was performed under a life-threatening emergency situation and prior acknowledgement was not possible.
    - Included a description of the nature of the emergency.

Providers must check eligibility for the date of service to determine Medicaid coverage in the event of retroactive member eligibility.

Recommended Fields for CMS-1500

All professional Providers and vendors should bill Anthem using the most current version of the *CMS-1500* claim form. The following guidelines will assist in completing the *CMS-1500* form. For more information, you may also refer to the Centers for Medicare

The following guidelines will assist in completing the *CMS-1500* form. For additional information, please refer to the *IHCP Provider Reference Modules* at **https://www.in.gov/medicaid/providers/469.htm**.

Form Locator	Narrative Description/Explanation
1	INSURANCE CARRIER SELECTION – Enter X for Traditional Medicaid. Required.
1a	INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) – Enter the IHCP member identification number (RID). Must be 12 digits. Required.
2	PATIENT'S NAME (Last Name, First Name, Middle Initial) – Provide the member's last name, first name and middle initial obtained from the Automated Voice Response (AVR) system, electronic claim submission (ECS), Omni, or Provider Healthcare Portal verification. Required.
3	PATIENT'S BIRTH DATE – Enter the Member's birth date in MM/DD/YY format. Optional. SEX – Enter X in the appropriate box. Optional.
4	INSURED'S NAME (Last Name, First Name, Middle Initial) – Not applicable.
5	PATIENT'S ADDRESS (No., Street), city, state, ZIP code, telephone (include area code) – Enter the Member's complete address information. Optional.
6	PATIENT RELATIONSHIP TO INSURED – Not applicable.
7	INSURED'S ADDRESS (No., Street), city, state, ZIP code, telephone (include area code) – Not applicable.
8*	RESERVED FOR NUCC Use – Not applicable.
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) – If other insurance is available, and the policyholder is other than the member shown in fields 1a and 2, enter the policyholder's name. Required, if applicable.

Form Locator	Narrative Description/Explanation
9a	OTHER INSURED'S POLICY OR GROUP NUMBER – If other insurance is available, and the policyholder is other than the member noted in fields 1a and 2, enter the policyholder's policy and group number. Required, if applicable.
9b*	RESERVED FOR NUCC USE – Not applicable.
9c*	RESERVED FOR NUCC USE – Not applicable.
9d	INSURANCE PLAN NAME OR PROGRAM NAME – If other insurance is available, and the policyholder is other than the member shown in field 1a and 2, enter the policyholder's insurance plan name or program name information. Required, if applicable.
10	IS PATIENT'S CONDITION RELATED TO – Enter X in the appropriate box in each of the three categories. This information is needed for follow-up third-party recovery actions. Required, if applicable.
10a	EMPLOYMENT (CURRENT OR PREVIOUS) – Enter X in the appropriate box. Required, if applicable.
10b	AUTO ACCIDENT – Enter X in the appropriate box. Required, if applicable. PLACE (State) – Enter the two-character state code. Required, if applicable.
10c	OTHER ACCIDENT – Enter X in the appropriate box. Required, if applicable.
10d*	CLAIM CODES (Designated by NUCC) – Not applicable.
Fields 11 and 11a through 11d are used to enter member insurance information.	
11	INSURED'S POLICY GROUP OR FECA NUMBER – Enter the member's policy and group number of the other insurance. Required, if applicable.
11a	INSURED'S DATE OF BIRTH – Enter the member's birth date in MMDDYY format. Required, if applicable. SEX – Enter an X in the appropriate sex box. Required, if applicable.
11b*	OTHER CLAIM ID (Designated by NUCC) – Not applicable.
11c	INSURANCE PLAN NAME OR PROGRAM NAME – Enter the member's insurance plan name or program name. Required, if applicable.
11d*	IS THERE ANOTHER HEALTH BENEFIT PLAN? – Enter X in the appropriate box. If the response is *Yes*, complete fields 9, 9a, and 9d. Required, if applicable.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – Not applicable.
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – Not applicable.
14*	DATE OF CURRENT ILLNESS (First symptom date) OR INJURY (Accident date) OR PREGNANCY (LMP date) – Enter the date of the last menstrual period (LMP) for pregnancy-related services in MMDDYY format. Required, if applicable Note: Qualifier code is not applicable.
15*	OTHER DATE – Enter date in MMDDYY format. Optional. Note: Qualifier code is not applicable.
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION – If field 10a is Yes, enter the applicable FROM and TO dates in a MMDDYY format. Required, if applicable.
17*	NAME OF REFERRING PROVIDER OR OTHER SOURCE – Enter the name of the referring physician. Required, if applicable. For waiver-related services, enter the provider or case manager name. Optional. Note: Qualifier code is not applicable. The term referring provider includes physicians primarily responsible for the authorization of treatment for lock-in or Right Choices Program members.

Form Locator	Narrative Description/Explanation
17a	ID NUMBER OF REFERRING PROVIDER, ORDERING PROVIDER OR OTHER SOURCE – Enter the qualifier in the first shaded box of 17a, indicating what the number reported in the second shaded box of 17a represents. Atypical providers should report the IHCP LPI provider number in the second box of 17a. Health care providers should report the taxonomy code in the second box of 17a. The qualifier is required when entering the IHCP LPI provider number or taxonomy. Qualifiers to report to IHCP: • G2 is the qualifier that applies to the IHCP provider number, also called the LPI for the atypical non-health care provider. The LPI includes nine numeric characters and one alpha character for the service location. • ZZ and PXC are the qualifiers that apply to the provider taxonomy code. The taxonomy code includes 10 alphanumeric characters. Taxonomy may be needed to establish a one-to-one NPI/LPI match if the provider has multiple locations. • Required, when applicable and for any waiver-related services. • Required, if applicable.
17b	NPI – Enter the 10-digit numeric NPI of the referring provider, ordering provider or other source. Required, if applicable.
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – Enter the requested FROM and TO dates in MMDDYY format. Required, if applicable.
19*	ADDITIONAL CLAIM INFORMATION. (Designated by NUCC) – May be used for claim notes if necessary.
20	OUTSIDE LAB? – Not applicable. CHARGES – Not applicable.
21 A-L* ICD Indicator	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – Complete fields 21A-L through field 24E by detail line. Enter the ICD diagnosis codes in priority order. A total of 12 codes can be entered. Required. ICD Ind –Enter 0 to indicate the diagnosis codes in fields 21A-L are ICD-10 diagnosis codes. Required.
22*	RESUBMISSION CODE, ORIGINAL REF. NO. – Applicable for Medicare Part B crossover claims and Medicare Replacement Plan claims. For crossover claims, the combined total of the Medicare coinsurance, deductible, and psychiatric reduction must be reported on the left side of field 22 under the heading Code. The Medicare paid amount (actual dollars received from Medicare) must be submitted in field 22 on the right side under the heading Original Ref No. Required, if applicable.
23	PRIOR AUTHORIZATION NUMBER (PA) – The PA number is not required, but entry is recommended to assist in tracking services that require PA. Optional.

<table>
<tr><th>Form Locator</th><th>Narrative Description/Explanation</th></tr>
<tr><td>24A to 24I
Top Half – Shaded Area</td><td>NATIONAL DRUG CODE INFORMATION – The shaded portions of fields 24A to 24I are used to report NDC information.
To report this information, begin at field 24A as follows:
1. Enter the NDC qualifier of N4
2. Enter the NDC 11-digit numeric code
3. Enter the drug description
4. Enter the NDC unit qualifier:
• F2 – International unit
• GR – Gram
• ML – Milliliter
• UN – Unit
5. Enter the NDC quantity (administered amount) in the format 9999.99.</td></tr>
<tr><td>24A*
Bottom Half 24B</td><td>DATE(S) OF SERVICE – PLACE OF SERVICE Provide the FROM and TO dates in MM/DD/YY format. Up to six FROM and TO dates are allowed per form. Required.
Use the POS code for the facility where services were rendered. For a list of POS codes, go to the Place of Service Codes overview page on the CMS website at www.cms.hhs.gov. Required.</td></tr>
<tr><td>24C</td><td>EMG – Emergency Indicator, this field indicates services were for emergency care for service lines with a CPT or HCPCS code in field 24D. Enter Y or N. Required, if applicable.</td></tr>
<tr><td>24D</td><td>PROCEDURES, SERVICES OR SUPPLIES
CPT/HCPCS – Use the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line. Required.
MODIFIER – Use the appropriate modifier, if applicable. Up to four modifiers are allowed for each procedure code. Required, if applicable.</td></tr>
<tr><td>24E*</td><td>DIAGNOSIS POINTER – Enter letter A-L corresponding to the applicable diagnosis codes in field 21. A minimum of one and a maximum of four diagnosis code references can be entered on each line. Required.
Note: The alpha value of A-L entered for the diagnosis pointer will be systematically converted to match the Electronic Data Interchange (EDI) value of 1-12 as depicted below.
<table>
<tr><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td><td>K</td><td>L</td></tr>
<tr><td>1_</td><td>2_</td><td>3_</td><td>4_</td><td>5_</td><td>6_</td><td>7_</td><td>8_</td><td>9_</td><td>10</td><td>11</td><td>12</td></tr>
</table>
</td></tr>
<tr><td>24F</td><td>$ CHARGES – Enter the total amount charged for the procedure performed, based on the number of units indicated in field 24G. The charged amount is the sum of the total units multiplied by the single unit charge. Each line is computed independently of other lines. This is a 10-digit field. Required.</td></tr>
<tr><td>24G</td><td>DAYS OR UNITS – Provide the number of units being claimed for the procedure code. Six digits are allowed and 9999.99 units is the maximum that can be submitted. The procedure code may be submitted in partial units, if applicable. Required.</td></tr>
<tr><td>24H</td><td>EPSDT FAMILY PLAN – If the patient is pregnant, indicate with a P in this field on each applicable line. Required, if applicable.</td></tr>
</table>

Form Locator	Narrative Description/Explanation
24I Top Half – Shaded Area	RENDERING ID QUALIFIER – Enter the qualifier indicating what the number reported in the shaded area of 24J represents –or G2 for IHCP LPI rendering provider number, or ZZ or PXC for rendering provider taxonomy codes. Required, if applicable. G2 are the qualifiers that apply to the IHCP provider number (LPI) for atypical non-health care providers. The LPI includes nine numeric characters. Atypical providers (for example, certain transportation and waiver service providers) are required to submit their LPIs. ZZ and PXC are the qualifiers that apply to the provider taxonomy code. The taxonomy code includes 10 alphanumeric characters. The taxonomy code may be required for a one-to-one match.
24J Top Half – Shaded Area	RENDERING PROVIDER ID – Enter the LPI if entering the G2 qualifier in 24I or the taxonomy if entering the ZZ or PXC qualifier in 24I for the rendering provider G2. Required, if applicable. LPI – The entire nine-digit LPI must be used. If billing for case management, the case manager's number must be entered here. Taxonomy – Enter the taxonomy code of the rendering provider. Optional unless required for a one-to-one match.
24J Bottom Half	RENDERING PROVIDER NPI – Enter the NPI of the rendering provider. Required, if applicable.
25	FEDERAL TAX I.D. NUMBER – Not applicable.
26	PATIENT'S ACCOUNT NO. – Enter the internal patient tracking number. Optional.
27	ACCEPT ASSIGNMENT – The IHCP Provider Agreement includes details about accepting payment for services. Optional.
28	TOTAL CHARGE – Enter the total of all service line charges in column 24F. This is a 10-digit field, such as 99999999.99. Required.
29	AMOUNT PAID – Enter the payment received from any other source, excluding the traditional Medicare or Medicare replacement plan paid amount. All applicable items are combined and the total entered in this field. This is a 10-digit field. Required, if applicable. OTHER INSURANCE – Enter the amount paid by the other insurer. If the other insurer was billed but paid zero, enter 0 in this field. Attach denials to the claim form when submitting the claim for adjudication.
30*	RESERVED FOR NUCC USE – Not applicable.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS – An authorized person, someone designated by the agency or organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not. Providers that have signed the Claims Certification Statement for Signature on File form will have their claims processed when a signature is omitted from this field. The form is available on the Forms page at http://indianamedicaid.com. Required, if applicable.
32	SERVICE FACILITY LOCATION INFORMATION – Enter the provider's name and address where the services were rendered, if other than home or office. This field is optional, but it helps HP contact the provider, if necessary. Optional.

Form Locator	Narrative Description/Explanation
32a	SERVICE FACILITY LOCATION NPI – Not applicable.
32b	SERVICE FACILITY LOCATION QUALIFIER AND ID NUMBER – Not applicable.
33	BILLING PROVIDER INFO AND PHONE # – Enter the provider service location name, address and the ZIP code+4 as listed on the provider enrollment profile. Required. Note: If the U.S. Postal Service provides an expanded ZIP code (ZIP code + 4) for a geographic area, this expanded ZIP code must be entered on the claim form.
33a	BILLING PROVIDER NPI – Enter the billing provider NPI. Required.
33b	BILLING PROVIDER QUALIFIER AND ID NUMBER – Health care providers may enter a billing provider qualifier of ZZ or PXC and taxonomy code. Taxonomy may be needed to establish a one-to-one NPI/LPI match if the provider has multiple locations. If the billing provider is an atypical provider, enter the qualifier G2 and the LPI. Required.

Section 2: Institutional Claims

Billing for hospitals and other health care facilities and services can require special attention because major services have their own set of billing requirements. This section is broken down into health service categories to help you find the specific billing codes you'll need for each one.

You will also find information on the proper method for filling out and specific coding guidelines for the standard hospital and health care facilities claim form, the *CMS-1450*.

Basic Billing Guidelines

In general, here are the basic billing guidelines you'll need for institutional claims submitted to Anthem:

- **Use HCPCS, CPT or Revenue Codes:** Valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically.
- **Split Year-End Claims:** Services that begin before or in December and extend beyond December 31st should be billed as a split claim at calendar year end. This is typically due to a member changing plans with an effective date of January 1. **Two** *UB-04* forms, either electronic or paper, must be used and must be submitted together.
- **Split Dates of Service for a Provider Contract Change:** When a provider contract change occurs during the course of treatment, reimbursement will default to the contract that is active at discharge.
- **Itemize Services:** Service itemization is required when the "From" and "Through" service dates are the same.
- **Provide Medical Records:** Medical records for certain procedures may be requested for determination of medical necessity.
- **Use Modifiers:** Use modifiers in accordance with your specific billing instructions.
- **Use Codes for Unlisted Procedures:** Some provider services or procedures are not found in CPT; therefore, specific code numbers for reporting unlisted procedures have been designated. When

an unlisted procedure code is used, will need a description of the service in order to calculate the appropriate reimbursement. Medical records may be requested.

- **Do Not Use CPT Code 99070:** This code, for supplies and materials provided over and above those usually included with an office visit or other services, is not accepted by Anthem. Health care Providers must use **HCPCS Level II Codes**, which give a detailed description of the service provided. Anthem will pay for surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be paid separately.

System edits are in place for both electronic and paper claims. Claims submitted improperly cannot be easily processed and could be denied.

National Drug Codes

See **National Drug Codes** on page 5.

Emergency Room Visits

The billing requirements for an emergency room visit apply to the initial treatment of a medical or psychiatric emergency, but only if the patient does not remain overnight. If the emergency room visit results in an admission, then all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care.
Reimbursement for emergency room services relates to the nature of the emergency diagnosis and can be based on urgent care rates, depending on the diagnosis. The billing requirements for emergency room treatment cover all diagnostic and therapeutic services, including, but not limited to:

- Equipment
- Facility use (including nursing care)
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the emergency room visit

Anthem will **not** reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition. There are three exceptions to this requirement:

- Anthem will reimburse the physician screening fee and facility fee, even if the condition is not an emergency
- Anthem will reimburse if the services were authorized by Anthem or if the primary medical physician referred the member for treatment
- Anthem will reimburse if the member called the 24/7 NurseLine and was advised to go to the emergency room

Anthem will review Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect emergency services claims to determine appropriate use of the emergency room and whether an emergency medical condition existed. At a minimum, both the facility and the physician will receive reimbursement for screening services:

- For physician services billed on a *CMS-1500* claim: If a prudent layperson review determines that the service was not an emergency, Anthem is required to reimburse, at minimum, for CPT code 99281, the Emergency Department Visit Level 1 screening fee.
- For facility charges billed on a *UB-04*: If a prudent layperson review determines the service was not an emergency, we must reimburse for revenue code 451, EMTALA Emergency Medical Screening Services.

Special emergency room billing instructions and requirements:
Specific coding is required for emergency room billing. Use the following guidelines, including:

- Bill each service date as a separate line item.
- Members should receive screening examination regardless of payment of copay
- No ER copay is necessary if the patient is admitted; the ER copay only applies to nonemergent services provided in an ER setting
- Use CPT codes 99284 or 99285 for emergency room billing.
- Use ICD principal diagnosis codes, as required, for all services provided in an emergency room setting.
- Use revenue codes 0450-0452, and 0459, as required.

Unless clinically required, follow-up care should never occur in the emergency department. Members should be referred back to their primary medical provider and correct billing should follow standard, nonemergency guidelines.

Urgent Care Visits

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital outpatient department or emergency room.

Urgent Care: Nonscheduled, nonemergency hospital services required to prevent serious deterioration of a patient's health as a result of an unforeseen illness or injury. Urgent care billing should detail all diagnostic and therapeutic services including, but not limited to:

- Equipment
- Facility use (including nursing care)
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the visit

Urgent care visits do not apply to those cases that are admitted and treated for inpatient care following urgent care treatment.

Special urgent care billing instructions:
Specific coding is required for urgent care billing. Use the following guidelines, including:

- Bill each service date as a separate line item.
- Use current ICD-10 principal diagnosis codes, as required, for all services provided in an urgent care setting or designated facility.
- Use the required CPT codes: 99281-83.
- Use the required revenue codes: 045X, 0516, 0526, 0700, 072X.
- Use billing code 99050 for after-hours care.

If the member is admitted following urgent care, then the entire billing requirement shifts to acute or sub-acute care.

Maternity

The billing requirements for maternity care apply to all live and stillbirth deliveries. They include payment for services including, but not limited to:

- Room and board for mother (including nursing care)
- Nursery for baby (including nursing care)
- Delivery room/Surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

The maternity care rate covers the entire admission, except for admissions approved for extension beyond the contracted time limit for continuous inpatient days. In such cases, the billing requirements for the entire admission shifts to those for inpatient acute care (later in this section) for each approved and medically necessary service day.

Therapeutic abortions, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under this rate.

For deliveries with dates of admission on or after July 1, 2014, one of the following condition codes must be included on the UB-04 claim form (when applicable), and when billing with CPT codes 59409, 59514, 59612 and 59620. CPT delivery codes 59410, 59515, 59614 and 59622 are not covered.

- 81: Cesarean sections or inductions performed at less than 39 weeks, zero days of gestation for medical necessity;
  - Claims with condition code 81 **and** one of the diagnosis codes on the *Medical Necessity Code List* will pay (you may find this list at **www.anthem.com/inmedicaiddoc** > **Prior Authorization & Claims** > **Forms and other resources**).
  - Claims with condition code 81 but without one of the codes from the *Medical Necessity Code List* require medical records demonstrating medical necessity for delivery are submitted with the claim. Submitted medical records will be reviewed prior to payment to determine if the delivery was medically necessary and the claim will pay/deny accordingly. In the case of denial, the right to appeal is retained.
  - Claims with condition code 81 but without one of the diagnosis codes from the *Medical Necessity Code List*, and no records submitted with the claim, will deny. The right to appeal is retained. Medical records may be submitted at the time of appeal request.
- 82: Cesarean sections or inductions performed at less than 39 weeks, zero days of gestation; use this condition code for deliveries prior to 39 weeks, zero days of gestation that do not meet the IHCP's stated guidelines for medically necessary deliveries (the exception is natural or spontaneous delivery prior to 39 weeks). (Refer to **Obstetrical and Gynecological Services** in the IHCP Provider References Modules for approved indications.) **These claims will automatically deny.** The right to appeal is retained.
- 83: Cesarean sections or inductions performed at 39 weeks, zero days of gestation or later; **these claims will automatically pay**.

Note: An institutional claim for a delivery that was the result of spontaneous labor, regardless of route of delivery, should be submitted without a condition code. Institutional claims submitted without a condition code because the delivery was the result of spontaneous labor will automatically pay.

Inpatient Acute Care

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed. They include, but are not limited to:

- Room and board (including nursing care)
- Emergency room (if connected to admission)

- Urgent care (if connected to admission)
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Surgery and recovery suites
- Other services incidental to the admission

Prior authorization is required for all admissions except standard vaginal delivery and Cesarean sections. Special billing instructions and requirements:

- Must be an Indiana Health Coverage Programs (IHCP) facility
- Utilization Management approval is required for all admissions, except routine deliveries
- Billing observation room or outpatient charges with an inpatient stay:
  - The dates reported on the CMS 1450 form in the "From" box of **Form Locator 6 (FL 6)** and **Form Locator 17 (FL 17)** should be the **same**. These charges should also reflect the date the patient was admitted as an inpatient to the hospital.
  - Using the "From" box of (FL 6) and (FL 17) to reflect the date of an observation stay or outpatient charges that may have occurred prior to inpatient admission is incorrect and may cause processing delays.

Hospital Assessment Fee

FSSA implemented a Hospital Assessment Fee (HAF) in accordance with Public Law 229-2011, SECTION 281 as enacted by the 2011 Session of the Indiana General Assembly. The fee is used in part to increase reimbursement to eligible hospitals for services provided in fee-for-service and managed care programs, and as the State's share of disproportionate share hospital (DSH) payments.

The HAF increases inpatient and outpatient reimbursement for eligible hospitals so that aggregate payments reasonably approximate the Medicare upper-payment limits without exceeding those limits. The increases in reimbursement will be based on adjusting factors that will be applied to the inpatient diagnosis-related group (DRG), inpatient level-of-care (LOC) per-diem rates and outpatient rates.

Hospital Stays of Less Than 24 Hours

When submitting claims for hospital stays of less than 24 hours, bill the claim as an Outpatient Hospital Services claim and follow these guidelines:

- Service Codes: Include the correct CPT/HCPCS codes for each service
- Line Items: Bill each service for each date as separate line items
- Revenue Codes: Bill the revenue codes with the appropriate CPT/HCPCS codes
- Type of Bill: Type of bill field entry must be 13X

Claims denied for a stay of less than 24 hours are claims that have the same admit and discharge date, or have a discharge date of the day after admission. Patients who are transferred out within 24 hours of admission should be billed as outpatient claims. This does not apply to neonatal claims, which are expressly one-day stays that fall under the following diagnosis-related groups (DRGs):

- DRG 637 – Neonate, died within 1 day of birth, born here
- DRG 638 – Neonate, died within 1 day of birth, not born here
- DRG 639 – Neonate, transferred less than 5 days old, born here
- DRG 640 – Neonate, transferred less than 5 days old, not born here

Inpatient claims with next day discharge are assumed to be less than 24 hours if medical records are not provided. Claims submitted for inpatient stays with the "through date" of service one day later than the "from date" of service will be subject to post payment review.

Inpatient Sub-Acute Care

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a licensed and accredited facility at the appropriate level of care.

Sub-Acute Care: Includes levels of inpatient care less intensive than those required in an inpatient acute care setting. Each inpatient sub-acute care admission is considered a separate admission from any preceding or subsequent acute care admission, and should be billed separately.
Covered services include, but are not limited to:

- Room and board (including nursing care)
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the admission

All sub-acute admissions require prior authorization and a treatment plan. The treatment plan must accompany the admission and include:

- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline
- A discharge plan and options that are individually customized and identified from the admission date, and that are carried forward from the admission date
- Weekly summaries for each discipline, and bi-weekly conference reports

Outpatient Laboratory, Radiology and Diagnostic Services

There are specific billing requirements for outpatient laboratory, pathology, radiology and other diagnostic tests. These include billing for services related to the diagnostic tests, including, but not limited to:

- Facility use
- Nursing care (including incremental nursing)
- Equipment
- Professional services
- Specified supplies and all other services incidental to the outpatient visit

Please note: Outpatient radiation therapy is excluded from this service category and should be billed under the requirements of the **Other Services** category.

Outpatient Surgical Services

There are specific billing requirements for outpatient surgical services. The billing requirements include, but are not limited to:

- Facility use (including nursing care)
- Blood
- Equipment
- Imaging services
- Implantable prostheses
- Laboratory
- Pharmaceutical
- Radiology
- Supplies

- All other services incidental to the outpatient surgery visit

Special outpatient surgical services billing instructions:
Specific dates, codes and medical records may be required for billing:

- Follow the billing requirements for outpatient surgery when the respiratory therapy department performs an ECG, EEG or EKG; do **not** apply the outpatient therapy billing requirements.
- Include service dates for each procedure (both principal and other).
- Include CPT/HCPCS codes for each surgical procedure in form locators 44 (HCPCS/RATES).
- Provide medical records when Anthem needs to review and determine the correct grouping for services not defined in the surgery grouping.
- Use billing field entry 13X.
- Use revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X and 0975, as required, with the appropriate CPT/HCPCS code.
- Use the CPT/HCPCS code, as mandated by the HIPAA, for outpatient surgery billing.

Outpatient Therapies

Outpatient therapy services include physical, occupational, speech and respiratory therapies. An outpatient therapy visit means a single service date. Billing requirements for these visits include, but are not limited to:

- Facility use (including nursing care)
- Therapist/professional services
- Equipment
- Pharmaceuticals
- Supplies
- Other services incidental to the outpatient therapy visit

Special outpatient therapies billing instructions:
There are specific requirements for billing outpatient therapies, including:

- Bill each service date as a separate line item.
- Use the required revenue codes, including:
  - Occupational therapy = 043X
  - Physical therapy = 042X
  - Respiratory therapy = 041X
  - Speech Therapy = 044X
- Use the applicable CPT/HCPCS codes, as required.

Outpatient Infusion Therapies and Pharmaceuticals

Outpatient Infusion Therapies
Billing requirements for outpatient infusion therapy visits apply to each outpatient hospital visit and include, but are not limited to:

- Facility use (including nursing care)
- Equipment
- Intravenous solutions (excluding pharmaceuticals)
- Kinetic dosing
- Laboratory
- Professional services
- Radiology
- Supplies (including syringes, tubing, line insertion kits, etc.)
- Other services incidental to the outpatient infusion therapy visit

Outpatient Infusion Pharmaceuticals
These billing requirements apply to drugs such as chemotherapy, hydration and antibiotics used during each outpatient infusion therapy visit. One important exception is for blood and blood products, which are billed under "other services."

Special outpatient infusion pharmaceuticals billing instructions:
Specific codes and service dates are required, including:

- Use revenue codes 026X, 028X, 0331, 0335 or 0940, as required, for each outpatient infusion therapy visit
- Use revenue code 0940 or 0949 with 36511-36513, 36515-36516 or 36522 CPT/HCPCS codes when billing for therapeutic aphaeresis claims
- List each drug for each visit as a separate line item and include the service date
- Use HCPCS codes, as required, for all pharmaceuticals when:
  - Billed with revenue codes 0250-0252, 0256-0259 or 063X; you must include the units with pharmaceutical CPT/HCPCS codes.
  - Billed with revenue codes 026X, 028X, 0331, 0335 or 0940.
- When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form

Hospital-Acquired Conditions/Present on Admission Indicators

The IHCP utilizes a hospital-acquired conditions (HAC) policy for Medicaid claims using its existing version 30 of the All Patient Diagnosis-Related Group (AP DRG) grouper. Hospitals are required to report whether each diagnosis on a Medicaid claim was present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included in the list of HACs in Table 8.13 and for which the condition was not present on admission, the HAC secondary diagnosis is not used for APR DRG grouping. That is, the claim is paid as though any secondary diagnoses included in the table below were not present on the claim.

HAC Categories and Corresponding CC or MCC Codes
For procedure codes, visit **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.**

Diagnosis	Codes
Foreign Object Retained After Surgery	HAC 1
Air Embolism	HAC 2
Blood Incompatibility	HAC 3
Pressure Ulcer Stages III & IV	HAC 4
Falls and Trauma: • Fracture • Dislocation • Intracranial Injury • Crushing Injury	HAC 5

Diagnosis	Codes
• Burn • Other Injuries	
Catheter-Associated Urinary Tract Infection (UTI)	HAC 6
Vascular Catheter-Associated Infection	HAC 7
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	HAC 8
Manifestations of Poor Glycemic Control	HAC 9
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	HAC 10
Surgical Site Infection Following Bariatric Surgery for Obesity	HAC 11
Surgical Site Infection Following Certain Orthopedic Procedures	HAC 12
Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	HAC 13
Iatrogenic Pneumothorax with Venous Catheterization	HAC 14

Present on Admission Indicator

POA is defined as a condition "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery are considered POA. A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*). CMS does not require a POA indicator for an external cause of injury code unless it is being reported as an "other diagnosis." Therefore, the IHCP does not require a POA indicator in the External Cause of Injury field locator 72. If a POA indicator is entered in the External Cause of Injury field, it is ignored and not used for APR DRG grouping.

An exemption for HAC/POA is Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) diagnoses following a total knee replacement or hip replacement for pediatric and obstetric patients. When all these conditions are present on the claim, the HAC/POA requirement is bypassed and *none* of the diagnosis codes included on the claim is suppressed.

Hospital-Acquired Condition List

The IHCP updated the list of hospital-acquired conditions (HACs) to comply with the federally defined list. The IHCP follows CMS' HAC determinations, including any future additions or changes to the current list of HAC conditions, as well as diagnosis codes that are exempt from HAC reporting. The list of exempt diagnosis codes can be found in the *Hospital-Acquired Conditions* page at **https://www.CMS.gov**.

Provider Preventable Conditions

CMS issued Change Request (CR) 6405 to instruct hospitals how to bill for erroneous surgeries. The IHCP adopted the CMS rule and does not cover surgical or other invasive procedures to treat particular

medical conditions when the practitioner performs the surgery or invasive procedure erroneously, including:

- Incorrect surgical or other invasive procedures
- Surgical or other invasive procedures on the wrong body part
- Surgical or other invasive procedures on the wrong patient

The IHCP also does not cover hospitalizations and other services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, that could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

The IHCP will deny payments to providers for inpatient, inpatient crossover, inpatient crossover Medicare Replacement Plan, outpatient, outpatient crossover, outpatient crossover Medicare Replacement Plan, physician, physician crossover, and physician crossover Medicare Replacement Plan claims when provider preventable conditions (PPC) are performed on a patient. These institutional and physician claims will deny when submitted with the following E codes:

- Y65.51 – Performance of wrong operation (procedure) on correct patient (existing code)
- Y65.52 – Performance of operation (procedure) on patient not scheduled for surgery
- Y65.53 – Performance of correct operation (procedure) on wrong side/body part

The following PPC modifiers must be submitted on physician, physician crossover, and physician crossover Medicare Replacement Plan claims indicating errors:

- PA – Surgery wrong body part
- PB – Surgery wrong patient
- PC – Wrong surgery on patient

Coding Guidelines – CMS-1450 Claim Form

All Medicare-approved facilities should bill Anthem using the most up-to-date version of the *CMS-1450* claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. The Healthcare Common Procedure Coding System (HCPCS) provides codes for a variety of services and consists of two main subsystems, referred to as Level I and Level II:

- **Level I:** Current Procedural Terminology (CPT) codes determined by the American Medical Association (AMA)
  - CPT codes are represented by 5 numeric digits
- **Level II:** Other codes that identify products, supplies and services not included in the CPT codes, such as ambulance services and durable medical equipment (DME)
  - These are sometimes called the alphanumeric codes because they consist of a single alphabetical letter followed by 4 numeric digits.
- In some cases, 2-digit/character modifier codes should accompany the Level I or Level II coding.

The CMS-1450 Revenue Codes
CMS-1450 revenue codes are required for all institutional claims.

Institutional Inpatient Coding
For institutional inpatient coding, use the guidelines in the following code manuals:

- Use current ICD applicable and procedure codes in Boxes 74-74e of the *CMS-1450* claim form when the claim indicates that a procedure was performed.
- Please refer to your provider's contract for diagnostic-related grouping (DRG) information.

Institutional Outpatient Coding
For institutional outpatient coding, use the guidelines in the following code manuals:

- **Healthcare Common Procedure Coding System** (HCPCS), published by the Centers for Medicare and Medicaid Services (CMS)
- **Current Procedural Terminology** (CPT) codes: refer to the current edition of the physicians' CPT manual, published by the AMA

When using an **unlisted** CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Recommended Fields for CMS-1450 (UB-04)

The following guidelines will assist in completing the CMS-1450 form. "R" indicates a mandatory field. For additional information, please refer to the IHCP Provider Reference Modules online at **https://www.in.gov/medicaid/providers/469.htm**.

Field #	Box Title	Description
1 (R)	Blank	Facility name, address, and phone number.
2	Blank	Required when the address for payment is different from that of the Billing Provider information located in Field 1.
3a	PAT. CNTL #	Member's account number.
3b	MED. REC #	Member's record number, which can be up to 20 characters long.
4 (R)	TYPE OF BILL	Enter the Type of Bill (TOB) code.
5 (R)	FED. TAX NO.	Enter the provider's Federal tax ID number
6 (R)	STATEMENT COVERS PERIOD	"FROM" and "THROUGH" date(s) covered by the claim being submitted
7	Blank	Leave blank.
8a–b (R)	PATIENT NAME	Member's name.
9a–e (R) (Optional)	PATIENT ADDRESS	Complete address (number, street, city, state, ZIP code, telephone number).
10 (R) (Optional)	BIRTHDATE	Member's date of birth in MM/DD/YY format.
11 (R) (Optional)	SEX	Member's gender.
12 (R)	ADMISSION DATE	Member's admission date to the facility in MM/DD/YY format.
13 (R)	ADMISSION HR	Member's admission hour to the facility in military time (00 to 23) format.
14 (R)	ADMISSION TYPE	Type of admission.

Field #	Box Title	Description
15 (R)	ADMISSION SRC	Source of admission.
16 (R)	DHR	Member's discharge hour from the facility in military time (00 to 23) format.
17 (R)	STAT	Patient status.
18–28	CONDITION CODES	Enter Condition Code (81) X0 – X9.
29	ACDT STATE	Accident State.
30	Blank	Leave blank.
31–34 (R)	OCCURRENCE CODE OCCURRENCE DATE	Occurrence code and date, if applicable.
35–36	OCCURRENCE SPAN (CODE, FROM, & THROUGH)	Enter dates in MM/DD/YY format.
37	Blank	Leave blank.
38	Blank	Enter the responsible party name and address, if applicable.
39–41	VALUE CODES (CODE & AMOUNT)	Enter value codes, if applicable.
42 (R)	REV. CD.	Revenue Code. Revenue codes are required for all institutional claims.
43 (R)	DESCRIPTION	Description of services rendered
44 (R)	HCPCS/RATE/HIPPS CODE	Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services and home health.
45 (R)	SERV. DATE	Date of services rendered.
46 (R)	SERV. UNITS	Number/units of occurrence for each line or service being billed.
47 (R)	TOTAL CHARGES	Total charge for each line of service being billed
48	NONCOVERED CHARGES	Enter any non-covered charges.
49	Blank	Leave blank.
50	PAYER NAME	Payer Identification. Enter any third-party payers.
51 (R)	HEALTH PLAN ID	Leave blank. Assigned by Plan.
52 (R)	REL. INFO	Release of information certification indicator.
53	ASG BEN.	Assignment of benefits certification indicator.
54	PRIOR PAYMENTS	Prior payments.
55	EST. AMOUNT DUE	Estimated amount due.
56 (R)	NPI	Enter the NPI number.
57 (R)	OTHER PRIV ID	Enter the other provider ID.
58 (R)	INSURED'S NAME	Member's name.
59 (R)	P. REL	Patient's relationship to insured (N/A: Member is the insured).

Field #	Box Title	Description
60 (R)	INSURED'S UNIQUE ID	For Hoosier Healthwise, use the 12-digit Medicaid ID number (Recipient Identification RID Number), along with the YRH prefix. For Healthy Indiana Plan, use the 9-digit Anthem ID number, along with the YRK prefix. For Hoosier Care Connect, use the 12-digit Anthem ID number, along with the YRH prefix.
61	GROUP NAME	Insured group name — enter the name of any other health plan.
62	INSURANCE GROUP NO.	Enter the policy number of any other health plan.
63	TREATMENT AUTHORIZATION CODES	Authorization number or authorization information must be entered on this field.
64	DOCUMENT CONTROL NUMBER	The control number assigned to the original bill.
65	EMPLOYER NAME	Name of organization from which the insured obtained the other policy.
66 (R)	DX/PROC qualifier	Enter the diagnosis and procedure code qualifier (ICD version indicator).
67 (R)	DX	Principal Diagnosis Codes. Enter the ICD-10 diagnostic codes, if applicable.
67a–q (R)	DX	Other Diagnostic Codes. Enter the ICD-10 diagnostic codes, if applicable. Indicate POA for inpatient claims.
68	Blank	Leave blank.
69	ADMIT DX	Admission diagnosis code — enter the ICD-10 code.
70a–c	PATIENT REASON DX	Enter the member's reason for this visit, if applicable.
71	PPS CODE	Prospective Payment System (PPS) code (not required).
72	ECI	External cause of injury code.
73	Blank	Leave blank.
74 (R)	PRINCIPAL PROCEDURE (CODE/DATE)	ICD-10 principal procedure code and dates, if applicable.
74a–e (R)	OTHER PROCEDURE (CODE/DATE)	Other Procedure Codes.
75	Blank	Leave blank.
76 (R)	ATTENDING	Enter the attending physician's ID number. (NPI required after May 23, 2007.)

Field #	Box Title	Description
77 (R)	OPERATING	Enter the provider number if you use a surgical procedure on this form. (NPI required after May 23, 2007.)
78–79	OTHER	Enter any other provider numbers, if applicable. (NPI required after May 23, 2007.)
80	REMARKS	Use this field to explain special situations.
81a–d (R)	CC	Enter taxonomy code with qualifier B3.

Section 3: Ancillary Claims

Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect follow ancillary billing guidelines as outlined in the IHCP Provider Reference Modules at **https://www.in.gov/medicaid/providers/469.htm**. Most ancillary claims are submitted for laboratory/diagnostic imaging or durable medical equipment (DME). This section will provide special billing requirements for each. The member's benefits may not cover some of the services listed. Please confirm benefit coverage.

Ambulance Services

Ambulance providers, including municipalities, should use the *CMS-1500* form to bill for ambulance services. Use the appropriate 2-digit origin and destination codes that describe the "to" and "from" locations.

Ambulatory Surgical Centers

Most outpatient surgery delivered in an ambulatory surgery center requires prior authorization. Ambulatory surgical centers bill on the *CMS-1500* form.

Physical Therapy

The physical therapy setting determines the correct billing form or successor forms:

- **Form CMS-1500:** When providing services in an office, clinic or outpatient setting
- **Form CMS-1450:** When providing services in a rehabilitation center
- **Form UB-04:** For physical therapists affiliated with home health agencies, providing services in a patient's home

Speech Therapy

The speech therapy setting determines the correct billing form or successor forms:

- **Form CMS-1500**: When providing services in an office, clinic or outpatient setting
- **Form UB-04**: For speech therapists affiliated with home health agencies, providing services in a patient's home

Occupational Therapy

The occupational therapy setting determines the correct billing form or successor forms:

- **Form CMS-1500**: When providing services in an office, clinic or outpatient setting

- **Form UB-04**: For occupational therapists affiliated with home health agencies, providing services in a patient's home

Durable Medical Equipment

Billing for custom-made durable medical equipment (DME), prescribed to preserve bodily functions or prevent disability, requires prior authorization. Without such review, claims for DME will be denied. Prior to dispensing, please contact Anthem's Utilization Management (UM) department.

Please note: The presence of a Healthcare Common Procedure Coding System (HCPCS) code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes may be By Report (customized) and therefore require additional information for pre-service review and processing.

Special Guidelines for Durable Medical Equipment Billing
Durable medical equipment billing requires a differentiation between rentals and purchased equipment. It also requires specific codes and modifiers.

- Use the appropriate modifier to identify rentals versus purchases (new or used). Claims submitted without the right modifier will be reimbursed at the rental rate.
- Use HCPCS codes for DME or supplies.
- Use an unlisted or miscellaneous code (such as E1399) when an HCPCS code doesn't exist for a particular item of equipment.
- Use valid codes for DME and supplies; unlisted codes will not be accepted if valid HCPCS codes exist.
- Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code. The invoice must be from the manufacturer, not the office making the purchase.
- Catalog pages are not acceptable as a manufacturer's invoice.

DME Rentals
Most DME is dispensed on a rental basis. These rentals require medical documentation from the prescribing provider. Rented items remain the property of the DME provider until the purchase price is reached. Charges for rentals exceeding the reasonable charge for a purchase are not accepted, and rental extensions may be obtained only on approved items. DME providers should use normal equipment collection guidelines. Anthem is not responsible for equipment not returned by members.

DME Purchase
DME may be reimbursed on a rent-to-own basis over a period of 10 months, unless otherwise specified at the time of review by our Utilization Management department.

DME Wheelchairs/Wheeled Mobility Aids
At Anthem, we follow Medicaid guidelines for calculating By Report (customized) wheelchair claims. Claims must include the following:

- Catalog number
- Item description
- Manufacturer's name
- Model number

Each catalog page or invoice line must be marked so it can be matched to the appropriate claim line. Also, the Reserved for Local Use field (Box 19) on the CMS-1500 form must be filled in with the total MSRP of the wheelchair, including:

- Accessories

- Modifications or replacement parts
- Name of the employed Rehabilitation and Assistive Technology of America (RESNA) certified technician

For wheeled mobility aids, there is one additional requirement: The invoice must be an amount published by the manufacturer before August 1, 2003. If the item was not available before then, you must list the date of availability in the **Reserved for Local Use** field (Box 19) of the CMS-1500 claim form. The catalog page where the item was first published must be attached to the claim. If you are a wheelchair manufacturer billing as a provider, your billing must include:

- If the item was not available before that date, the manufacturer's invoice must accompany the claim
- The initial date of availability must be documented in the Reserved for Local Use field (Box 19) of the *CMS-1500* claim form

Dialysis

Dialysis centers and other entities performing dialysis should use the CMS-1450 form to bill for dialysis services. All dialysis care must be pre-authorized (except where Medicare is the primary payer). Contact Anthem's Utilization Management (UM) department for authorization prior to delivery of service.

Home Infusion Therapy

Home infusion therapy requires prior authorization. When billing for home infusion therapy, use the CMS-1500 form and follow these guidelines:

- Get prior authorization, as required, from Anthem's Utilization Management (UM) department for all infusion therapy.
- Submit all claims within the contracted filing limit.
- Use the appropriate HCPCS injection codes to bill for all injections.
- Use HCPCS code J3490 along with the National Drug Code (NDC) for billing injections only if an appropriate injection code is not found.

Please Note: By Report HCPCS codes, including HCPCS code A9999 for supplies and accessories, are reimbursed at the lesser of the amount billed **or** the manufacturer's purchase invoice amount, plus a 24% mark-up.

Laboratory and Diagnostic Imaging

For laboratory and diagnostic imaging, use the *CMS-1500* form and refer to the basic billing guidelines found in the beginning (**Overview**) of this segment, **Billing Professional Claims**.

Skilled Nursing Facilities

All skilled nursing facility care requires prior authorization. Contact Anthem's Utilization Management (UM) department for authorization prior to SNF admission and bill using the *CMS-1450* form. Use codes: **0550-52, 0559, 90300-903XX**.

Home Health Care

All home health care must be preauthorized. Contact Anthem's Utilization Management (UM) department for authorization prior to delivery of service. When billing for a home health care visit, use the *CMS-1450* form. When billing for supplies and equipment used in a home health care visit, please refer to the **Durable Medical Equipment** section (earlier in this chapter) for billing requirements.

Hospice

Prior authorization for inpatient and outpatient hospice services for Healthy Indiana Plan (HIP) and Hoosier Care Connect is not required. Bill for hospice services on the *CMS-1450* form.

Notification is required for who reside in a nursing facility and have elected the hospice benefit. Notification is **not** required for home hospice.