VEI Indianapolis Medical Management

7330 Shadeland Station #200
Indianapolis, IN 46256

January 2009
IMM INSIGHT NEWSLETTER

January 2009

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Attention: Very Important Denial Code

Beginning January 5th Medicare will be adding a new denial code. This code will be (CARC) **213.** Any office that receives this denial code should **immediately** contact their office manager or account manager. If this denial message is received, Medicare believes that there has been non-compliance with the physician self-referral prohibition legislation. Offices will need to research the issue promptly.
This denial code requires immediate action by the office administration and should **not be delayed** or worked within normal time frames or processes. If denial code 213 is received from Medicare, it must be elevated to the appropriate manager upon receipt.
If you need additional information, please contact your Billing/Coding consultant.

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Medicaid Updates

Effective 3/1/2009 Hoosier Healthwise, in an effort to keep patients from changing networks repeatedly, has developed an open enrollment period. Offices still need to check Medicaid eligibility on the date of service. Please do not assume that a patient has not changed networks.

To enhance continuity of care, the Hoosier Healthwise program will implement Open Enrollment effective March 1, 2009. Open Enrollment is an improvement to the Hoosier Healthwise program. Currently, Hoosier Healthwise members can change their health plans at any time. Under Open Enrollment, members can change health plans only at the following times:

- Anytime during their first 90 days enrolled with a new health plan
- Annually during their open enrollment period
- Anytime there is "just cause"

Go to BT200841 for more information.

These claims denied in error:
Please resubmit *Denial: Care Select* Providers Claims Denied for Edit 1049 – Care Select *member's PMP is missing*

From May 23, 2008, through October 22, 2008, claims were inappropriately denied for edit 1049 – *Care Select member's PMP is missing or invalid*. EDS updated the claim processing system on October 22, 2008, to correct the problem. **If you received this denial for claims during this time frame, please resubmit denied claims for processing.**

Top 10 Reasons Claims Are Denied Summarized (NL200812)

1. ***Denial Code 558 – Coinsurance and deductible*** amount missing on crossover claims. Please follow Medicaid's directions for line 22 on the HCFA. "CMS-1500 crossover claims – The combined total of Medicare coinsurance, deductible, and psych reduction must be reported on the left side of field 22

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Medicaid Updates (continued)

under the heading code of the CMS-1500 claim form. The Medicare paid amount (actual dollars received from Medicare) must be submitted in field 22 on the right side of the CMS-1500 claim form under the heading, Original Ref No." NL200812

2. ***Denial Code 5001 – Duplicate Claim*** – Monitor your Medicaid claims online via the Web Interchange on a weekly basis. You will get more up to date information and can see why the claim denied or if it is being paid.
3. Claims will deny if services denied by Medicare are not submitted on separate claim forms with Medicare denials.
4. ***The recipient is enrolled in the RBMC program***. Check Medicaid eligibility online for that particular date of service and re bill the claim to the correct MCO.
5. ***Recipient covered by private insurance*** – The Medicaid eligibility page online tells you if they have other insurance. If certain exceptions have not been met Medicaid cannot be billed primary. See the exceptions listed and how to proceed if your claim falls into one of the exceptions.
   a. The service is not covered under the primary insurance policy.
   b. The benefits of the primary insurance policy are exhausted.
   c. The recipient is ineligible for the coverage.
   d. The insurance carrier cannot identify the policyholder.
   e. The insurance carrier cannot identify the patient (Make sure the termination date is before the dates of service on the claim)
   f. It has been more than 90 days since the date of service, and there has been no response from the insurance carrier.
   g. It has been more than 30 days since the date of service and there has been no response from the court-ordered absent parent who was to pay medical support.
6. ***Procedure code is not covered for the dates of service for the program billed***- Always make sure to check limitations at the bottom of the eligibility page to make sure they haven't used up a certain benefit for that quarter. Also, refer to the IHCP Medicaid fee schedule on the IHCP Web sit at http://indianamedicaid.com to see if it is a covered benefit.
7. ***A nonsurgical service is not reimbursed individually if performed in conjunction with an outpatient surgery*** – All charges that are performed on the same day need to be on the same claim.

8. ***National Drug Code (NDC) is missing*** - Submitted NDCs must be 11 characters long and must appear in the five-four-two configuration. For example, 12345-1234-12 is a correctly configured NDC. Also, zero can be a valid digit in an NDC, which may lead to confusion if you are trying to equate the NDC to its FDA standard. For example, 12345-0678-09 (11 digits) could appear as 12345-678-09 or as 12345-0678-9 on a drug's label, depending on the labeler's configuration. To ensure proper payment of claims, NDCs must be exactly 11 characters long. Add zeros to the left of a section of the NDC if needed. For example, if the FDA standard is 12345-678-9, add a zero to the left of the second and third sections of the number to make it 12345-0678-09.

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Medicaid Updates (continued)

9. ***Quantity dispensed or information administered is missing*** Claims will deny if the NDC quantity-dispensed information is missing. To include the quantity on a claim, enter the NDC quantity (administered amount) with up to three decimal places, such as 1234.567.
10. ***NDC unit qualifier (unit of measure) missing -*** Claims will deny if the NDC unit qualifier is missing. Please use the following qualifiers when submitting claims with procedure codes that require NDCs:
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN – Unit

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Emergency Eyewash Stations….what are the requirements?

Every employer with employees exposed to corrosive chemicals is responsible for the safety and health of their employees. Many physician practices have and use corrosive or hazardous chemicals in their facilities and it is important for employees to understand how to protect themselves in case of an exposure to these chemicals. Many of the material safety data sheets (MSDS) for products used in your facility indicate the need for an emergency eyewash station in case of accidental exposure to the eyes. In simple terms, an eyewash station is needed in the workplace because of hazardous chemicals or products used in the workplace. An eyewash station would also be used to flush out the eyes after accidental exposure to blood or other potentially infectious material (OPIM).

OSHA states:

29 CFR 1910.151(c) states that "where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided *within the work area for immediate emergency use"*.

The OSHA standard does not set specifications for emergency eyewash stations, but defers to ANSI (American National Standards Institute) which is the accepted guideline or standard for emergency eyewash stations. The ANSI standard states that it *establishes minimum performance and use requirements* for eyewash equipment for the emergency treatment of the eyes of a person who has been exposed to injurious materials, (i.e. hazardous chemicals as identified in the Hazardous Communication Standard.) It should also be noted that, in addition to the OSHA requirement for emergency flushing, there are also requirements for personal protective equipment (PPE) when employees are exposed to the hazards and corrosive chemicals present. PPE may include, but is not limited to, protection for the eyes, face and hands, as well as protective clothing. The purpose of PPE is to prevent injury, whereas the purpose of the eyewash is to minimize injury, should that first line of defense fail.

ANSI specifications:

1. All employees shall be instructed on the location and the use of the emergency eyewash unit. It should be clearly marked and in an accessible location, no more than 10 seconds or 50 feet away.

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Emergency Eyewash Stations (continued)

2. Place proper signage above eyewash stations labeling it, "Emergency Eyewash."
3. Walkways to the eyewash station should always be clear.
4. Eyewash units must supply flushing fluid to both eyes simultaneously.
5. Facilities should have a plumbed or self-contained unit that provides proper flushing. (A self-contained unit is one that has enough fluid to provide continuous irrigation for a minimum of 15 minutes at a rate of 0.4 gallons per minute. Plumbed units generally flow at a rate of 3 gallons per minute.)
6. The unit shall be positioned with the nozzles not less than 33 inches and no greater than 45 inches from the level on which the user stands and 6 inches minimum from the wall or nearest obstruction.
7. The nozzles shall be protected from airborne contaminants.
8. Once activated, the unit shall be able to be used without requiring the use of the operator's hands. The unit shall be designed to provide enough room to allow the eyelids to be held open with the hands while the eyes are in the flushing fluid stream.
9. Plumbed eyewash units shall be activated weekly for a period long enough to flush the line and to verify proper operation.
10. **Personal eye wash units/bottles are not** meant to supplement permanent eyewash stations; **eyewash bottles do not** meet the criteria of plumbed or self-contained units.
11. The ANSI standard does not specify water temperature. It does list temperatures between 60 degrees and 90 degrees Fahrenheit as a comfortable range that would encourage an injured employee to flush the eye for approximately 15 minutes.

If you have questions, please contact your Clinical Regulatory Consultant.

References:

ANSI Z358.1-2004
OSHA 1910.151(c)

CALENDAR OF HEALTH OBSERVANCE DATES

Blood Donor Month, National
Birth Defects Prevention Month
Cervical Cancer Screening Month

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