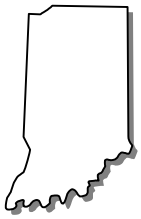


IMPORTANT INFORMATION

BR200245 NOVEMBER 5, 2002

To All Dental Providers:

- This reminds providers that the Indiana Health Coverage Programs (IHCP) bulletin, *BT200250*, dated September 15, 2002, notified dentists billing for prophylaxis and fluoride provided on the same day to children from one to 12 years old, that effective for dates of service on or after November 1, 2002, providers should bill with *D120 – topical application of fluoride-child which includes prophylaxis*. The rate for D1201 is $47.75. For children and adolescents 13 to 20 years old, providers should bill D1205 when billing for prophylaxis and fluoride on the same day. The rate for D1205 is $61.

  BT200250 also notifies providers of a 50 percent reduction in dentures and partials. If a dental provider believes a product purchased at a lower rate is not of the same quality as those purchased for private pay patients, the provider can refer the patient to another dentist who continues providing dentures or partials for IHCP patients.

To All Physicians:

- Chapter 8 of the *IHCP Provider Manual* states that the IHCP began reimbursing for postoperative epidural catheter management services using procedure code 01996 for dates of service on or after January 1, 1997.

  The IHCP does not pay for procedure code 01996 when it is billed for the same day the epidural is placed, but claims for this procedure code are billable on subsequent days when the epidural is being managed. This code is used for daily management of patients receiving continuous epidural, subdural, or subarachnoid analgesia, and is limited to one unit of service for each day of management. Procedure code 01996 is only reimbursable during active administration of the drug.

  Current Procedural Terminology (CPT) codes 99231, 99232, or 99233, for subsequent hospital care, are used for medically necessary, nonroutine postoperative visits, such as when an anesthesia provider sees the patient for potential problems experienced after epidural, subdural, or subarachnoid analgesia has been discontinued.

To All Acute Care Hospital Providers:

- This corrects information presented in Chapter 8 of the *IHCP Provider Manual* regarding treatment room visits. Treatment room visits are billed using revenue codes 45X, 51X, 52X, 70X, 72X, and 76X. Additionally, treatment room services are reimbursed at a flat rate that includes most drugs and supplies.

  The *IHCP Provider Manual,* published on April 30, 2002, incorrectly states, "Reimbursement is limited to a maximum of one unit per day, per revenue code, per member, per provider." The correct statement is: Reimbursement is limited to one unit per day, per patient, per provider. For more information about the outpatient prospective payment system and billing guidelines, refer to chapters 7 and 8 of the *IHCP Provider Manual* which is available on the IHCP Web site at www.indianamedicaid.com, or direct questions to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

- The Surveillance and Utilization Review (SUR) Department identified utilization concerns related to errors in assignment of patient discharge status codes by acute care facilities. Instances of incorrect discharge status code assignment have resulted in significant overpayment of claims from the IHCP. SUR is advising all providers to carefully review and ensure proper discharge status code assignments. To recoup overpayments, the SUR Department is conducting a review of these claims.

  Special payment policies apply to transfer cases paid using the diagnosis-related grouping (DRG) methodology. The receiving, or transferee, hospital is paid according to the DRG or level-of-care (LOC) methodology, whichever is applicable. Transferring hospitals are reimbursed a prorated DRG daily rate for each day, not to exceed the full DRG amount.

  To ensure proper reimbursement, the following discharge status codes must be placed in box 22 on the UB-92 claim form:

  - 02 – discharge or transfer to another short-term hospital for inpatient care.
  - 05 – discharge or transfer to another type of institution for inpatient care.

  All transfers are subject to retrospective review. To obtain specific instructions for billing transfers, see Chapter 8 of the *IHCP Provider Manual* or refer questions about patient discharge status codes to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. If a provider identifies overpayments related to such errors, the provider should file an adjustment or contact the SUR Department to arrange for repayment of inappropriate reimbursement.

To All Providers:

- The Indianapolis workshop to be held November 15, 2002, at St. Vincent's Hospital is at capacity. **No walk-ins will be accepted**.
- EDS requests that providers not staple, paper clip, or physically attach in any way claims to their attachments. Not stapling or paper clipping allows claims to process more effectively and efficiently.

To Pharmacy Providers:

> *Note: The information referenced below is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.*

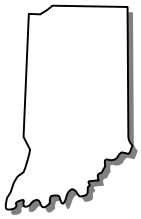
- The following labelers have entered into drug rebate agreements and have joined the rebate program with a mandatory coverage date of January 1, 2003:

New Labelers	
Company	**Labeler Code**
Weeks & Leo Co., Inc.	11383
International Ethical Labs	11584
Western Research Laboratories	64727
Aero Pharmaceuticals, Inc.	66440
aaiPharma	66591
Pro-Pharma LLC	66594
Vindex Pharmaceuticals, Inc.	67204
TEAMM Pharmaceuticals, Inc.	67336

- Thames Pharmaceuticals, labeler code 49158, was purchased by Taro Pharmaceuticals and has been reinstated as a labeler. The mandatory start date for Thames Pharmaceuticals is October 1, 2002.
- The following labeler, Sanofi-Synthelabo, Inc., labeler code 08024, is terminated effective October 1, 2002
- The following labeler codes are terminated effective January 1, 2003:

Terminated Labelers	
Company	**Labeler Code**
Seatrace Pharmaceuticals	00551
Warner-Lambert Company	11370
Concord Laboratories	20254
Med – Derm Pharmaceuticals	45565
Heran Pharmaceuticals, Co., Inc.	50434
Zenith Goldline Pharmaceuticals	50732
Ohm Laboratories, Inc.	51660
3M Pharmaceuticals	55326
Lini, Inc.	58215
Welgen, A Division of BW Co.	61054
Inkine Pharmaceuticals	61607
A&Z Pharmaceuticals	62211
Medical Merchandising Inc.	63913
LiquiSource, Inc.	66572

Voluntary Terminations	
Company	**Labeler Code**
Pharmacia Corporation	00016, 00601, and 42987
GlaxoSmithKline	00081
RxHoldings, LLC	08367
D&K Healthcare Resources, Inc.	05304, 07985, and 78622
Highland Packaging Company	55782
The Medicines Company	65293
DrugAbuse Sciences	65694



IMPORTANT CROSSOVER UPDATE

NOVEMBER 5, 2002

To All Providers

- Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200245*, dated August 13, 2002, stated Medicare Part A and C crossover claims would be released on October 1, 2002. To ensure all claims process according to current policy, additional review of claims is necessary. Therefore, the release of Medicare Part A and C claims will occur the week of November 4, 2002.
- In addition, *BT200245* also stated that as of August 15, 2002, all paper crossover claims must be submitted on the original red UB-92 claim form. Although the original red UB-92 claim forms are preferred, EDS will accept laser or computer generated claim forms. All claim forms must be clear and legible to ensure proper imaging and character recognition.
- Medicare Part B claims submitted with unlisted, unspecified, or miscellaneous codes must be submitted on paper with the proper documentation to support the cost of the item. Refer to the *IHCP Provider Manual*, Chapter 8, for acceptable documentation to support an item's cost. Electronic Medicare Part B crossover claims that contain a Health Care Procedure Coding System (HCPCS) code that requires manual pricing will systematically deny for EOB *9008– Line item submitted with unclear itemization. Please resubmit with appropriate or additional information. Electronic Medicare Part B claims submitted for services that require manual pricing must be billed on paper with an itemized cost invoice.*
- As a reminder, claims submitted for services covered by Medicare under a different HCPCS code than allowed by the IHCP will deny for EOB 4021 – *Procedure code is not covered for the date of service, for program billed. Please verify and resubmit;* EOB *4013 – This procedure code is not covered for this date of service;* EOB *4014 – No pricing segment is on file;* EOB *4033 – The modifier used is not compatible with the procedure code billed. Please verify and resubmit;* or, EOB *4209 – No matching pricing segment for the procedure or modifier combination billed on the HCFA 1500 claim form. Please refer to the provider procedures manual for the appropriate use of the modifiers TC, 26, RR, and NU.* Services in these categories may include, anesthesia care billed with the ASA codes and durable medical equipment (DME) items submitted with K codes and some G codes. Impacted Medicare Part B claims must be submitted on paper with the proper IHCP covered HCPCS code.
- EDS performed an extensive analysis of electronic Medicare Part B claims for mental health services rendered by a health service provider in psychology (HSPP). It was discovered that in some instances electronic Medicare Part B claims reflect the provider's group number as both the billing, *Field 33*, and rendering, *Field 24K*. This happens when both the individual provider rendering Medicare number is linked to the group's IHCP provider number. In the event the group provider number does not contain a provider specialty of 114-HSPP, claims billed with the AH modifier will calculate the IHCP allowance at 75 percent of the IHCP Fee Schedule amount. EDS Provider Enrollment is reviewing provider files that have individual rendering provider number(s) loaded incorrectly. EDS will contact each provider directly to verify and make changes necessary to correct the file. When all enrollment files are updated, EDS will perform a systematic mass adjustment for all claims billed with the AH modifier, that previously calculated the IHCP allowed amount at 75 percent instead of 100 percent for HSPP performed services.
- Ambulatory Surgery Center (ASC) claims that crossover from Medicare currently calculate the IHCP allowable amount based on the IHCP Fee Schedule for physicians instead of using the ASC pricing logic. System modifications will be implemented that allow Medicare Part B claims, submitted by provider type 02 and specialty 020 (ASC), to calculate the claim allowance based on normal ASC pricing. When the system modification is complete, all Medicare Part B claims billed by an ASC provider type and specialty will be systematically mass adjusted. Monitor future banner page articles for details about this issue.

- Medicare Part B coverage is available for routine service and maintenance of DME items. Claims submitted with the MS modifier append to the HCPCS code to denote the claim is for routine maintenance of the item. IHCP policy is that routine maintenance or repairs for items still under warranty are noncovered services. However, IHCP policy dictates that Medicaid must cover services allowed by Medicare. Therefore, EDS is developing a pricing methodology that allows the system to calculate an IHCP allowed amount to be used for Medicare Part B crossover claims only. When this pricing methodology is developed, EDS will systematically reprocess all Medicare Part B claims billed with the MS modifier and a date of service on or after July 1, 2002. Monitor future banner page articles for details regarding this issue.
- To ensure proper reimbursement for Federally Qualified Health Center (FQHC) and rural health clinic (RHC) providers, the July 1, 2002, Medicare/Medicaid crossover pricing methodology for provider type 08 and provider specialty 080 and 081, will be modified to allow the full Medicare coinsurance and deductible. EDS will perform the necessary system modifications the week of October 14, 2002. Medicare Part B claims impacted by this modification will systematically mass adjust the week of October 28, 2002. The system modifications will be in place for the November release of Medicare Part C claims; therefore, a mass adjustment is not required.
- EDS is in the process of making modifications to the remittance advice (RA) for Medicare Part A, B, and C claims. When the modifications are complete, the RA will display the following additional information for Medicare Part B and C claims:
  - All line item details
  - IHCP allowed amount for all line item details
  - Medicare paid amount
  - Total IHCP allowed for the claim
- The following additions will be made for Medicare Part A claims:
  - Diagnosis related grouping (DRG)
  - Medicare paid amount
  - IHCP total allowed for the claim
- The following item will be removed from the Medicare Part A claims:
  - Admit date