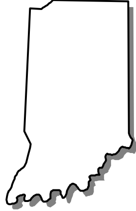

PROVIDER BULLETIN

BT200018 JUNE 1, 2000

To: All Indiana Health Coverage Programs Providers

Subject: Package C Claim Update

Overview

The purpose of this bulletin is to provide coverage and reimbursement guidelines associated with the implementation of the Hoosier Healthwise Package C– Children's Health Plan. The topics addressed in this bulletin include the following:

- Pharmacy coverage and claim submission guidelines
- Emergency room copayment policy change
- Review of Hoosier Healthwise benefit packages
- Upcoming changes to the Eligibility Verification System
- New Hoosier Healthwise Package C claim audits
- Contact information

Pharmacy Coverage and Claim Submission Guidelines

Providers were notified in bulletin *BT200006* of billing policies and procedures impacted by the restructuring of the IHCP and implementation of the Hoosier Healthwise Package C – Children's Health Plan.

Pharmacy providers are reminded that for Hoosier Healthwise Package C members, providers may substitute the generic equivalent of a brand name drug only when a prescribing physician has indicated on the written or verbally communicated prescription that the generic equivalent may be substituted. **If the prescribing physician has indicated that the medication should be dispensed as written, the pharmacist must dispense the drug prescribed.**

Pharmacy providers can receive the brand name price for drugs dispensed to Package C members if the prescriber indicates dispense as written (DAW) or brand medically necessary (BMN) and the pharmacist indicates the DAW code of **6** on the claim form. Table 1.1 identifies the placement of the DAW code on the claim forms and electronic submission.

Table 1.1 – Placement of DAW Codes

Form	Location
Drug claim form	Locator 10
Compound drug form	Locator 9
Any electronic submission	BMN indicator

Emergency Room Copayment Policy Change

Providers were notified in bulletin *BT200006*, of a $20 member copayment for emergency room visits that do not result in a hospital admission. New Indiana legislation has been adopted that eliminates the copayment for any emergency room services for Package C members effective July 1, 2000. Therefore, **the $20 copayment that is currently assessed to Package C outpatient emergency room claims not resulting in an admission ends June 30, 2000.**

Review of Hoosier Healthwise Benefit Packages

Providers were notified in bulletin *BT199928, Hoosier Healthwise Package C Overview Bulletin,* dated October 29, 1999, of the three programs that constitute the IHCP and the associated benefit packages. *BT199928* also identified that the Indiana Medical Assistance Programs name had been changed to the **Indiana Health Coverage Programs.** Along with this new name, the OMPP and the CHIP Office categorized all covered benefits into three distinct programs.

- 590
- Traditional Medicaid
- Hoosier Healthwise

> *Note:* ***The term Hoosier Healthwise no longer refers exclusively to managed care programs. This term has been broadened to encompass the various managed care components and many other IHCP benefit packages.***

Hoosier Healthwise is currently defined as indicated in Table 1.2.

Table 1.2 –Hoosier Healthwise Benefit Packages

Benefit Package	Coverage
Package A – Standard Plan	Full coverage for children, low-income families, and some pregnant women
Package B – Pregnancy Coverage Only	Pregnancy-related and urgent care services for some pregnant women
Package C – Children's Health Plan	Preventive, primary and acute care services for some children aged 18 and under
Package D – Hoosier Healthwise for Persons with Disabilities (HHPD) and Chronic Illnesses (Ended December 31, 1999)	Full coverage with case management services
Package E – Emergency Services Only	Individuals enrolled in this package are eligible for emergency services only

The IHCP issued a comprehensive benefit comparison chart in bulletin, *BT200006, Package C Claim Submission and Coverage Information,* dated January 20, 2000. The *Hoosier Healthwise Benefit Package Comparison* chart is an important tool for use in understanding coverage and limitations for all benefit packages within the Hoosier Healthwise Program.

Note: Providers are reminded that Package D - Hoosier Healthwise for Persons with Disabilities (HHPD) and Chronic Illnesses ended December 31, 1999.

Upcoming Changes to the Eligibility Verification System

Bulletin *BT200019, Package C Eligibility Verification System Update*, dated June 8, 2000, outlines enhancements to the automated voice-response (AVR) system and the OMNI swipe card components of the Eligibility Verification System (EVS). Specifically, ***BT200019* will introduce additional limitation audits that will be added to the announcement/display systems of AVR and OMNI. The changes addressed in this bulletin go into effect June 8, 2000.**

Note: Providers are reminded that it is important to listen to or review the entire message received for a member inquiry through EVS. This action is critical because there may be information about a member's eligibility that may impact covered services and reimbursement.

New Claim Audits for Package C

Tables 1.3 and 1.4 represent explanation of benefit (EOB) codes associated with services rendered to members enrolled in Hoosier Healthwise Package C.

Table 1.3 – Explanation of Benefit Codes for Package C Effective January 1, 2000

Edit Code	Description
1037	Private duty nursing is not covered in Package C.
2033	Package C member is not eligible for claim type.
4002	NDC indicates a non-covered drug on the date of service.
4003	Less than effective drugs are not covered under Indiana Health Coverage Programs.
4021	Procedure code is not covered for the dates of service for the program billed.
4062	Organ transplants are non-covered for Package C.
4067	ICD-9-CM procedure code is non-covered.
4077	The revenue code billed is non-covered.
4082	Bed reservation rendered in an institution for mental health diseases is a non-covered service for Package C.
4083	Inpatient care rendered in an institution for mental health diseases is not covered for Package C.
4126	Over-the-counter and non-legend drugs are not covered for Package C.

Table 1.4 – Explanation of Benefit Codes for Package C Effective January 1, 2000

Audit Code	Description
6111	Reimbursement is limited to five chiropractic office visits per year per member. This member has received the maximum number allowable.
6112	Therapeutic physical medicine treatments by a chiropractor are limited to 14 per member per calendar year. This member has received the maximum number allowable.

(Continued)

Table 1.4 – Explanation of Benefit Codes for Package C Effective January 1, 2000

Audit Code	Description
6113	Reimbursement for durable medical equipment is limited to $2,000 per member per calendar year. Prior authorization will override this audit.
6114	Reimbursement for durable medical equipment is limited to $5,000 per member per lifetime.
6115	Reimbursement is limited to 50 physical therapy treatments per member per calendar year. This member has received the maximum number allowable.
6116	Reimbursement is limited to 50 speech therapy treatments per member per calendar year. This member has received the maximum number allowable.
6118	Reimbursement is limited to 50 occupational therapy treatments per member per calendar year. This member has received the maximum number allowable.
6119	Reimbursement is limited to 50 days of inpatient rehabilitation services per member per calendar year. This member has received the maximum number allowable.
6120	Reimbursement is limited to 30 visits for outpatient mental health/substance abuse services per calendar year without prior authorization. This member has received the maximum allowable.
6121	Reimbursement is limited to 50 visits maximum for outpatient mental health/substance abuse services per member, per calendar year, with prior authorization. This member has received the maximum number allowable.
6122	Therapeutic physical medicine treatments exceeding 14, up to a maximum of 50, per member, per calendar year, require prior authorization.

Note: Providers are reminded that they may bill Package C members for non-covered services. However, a provider must inform the member's family that this service is non-covered prior to rendering the service. Please refer to the Indiana Health Coverage Programs Provider Manual, Chapter 4, Section 4 for information about charging a member for non-covered services.

Contact Information

The following identifies bulletins previously published about the restructuring of the IHCP and the implementation of Hoosier Healthwise Package C:

- *BT199928, Hoosier Healthwise Package C Overview*, dated October 29, 1999

- *BT199929, Package C Training Schedule*, dated November 24, 1999
- *BT199942, Package C Eligibility Verification System Updates*, dated December 3, 1999
- *BT200006, Package C Claim Submission and Coverage Information*, dated January 20, 2000
- *BT200008, Upgrade to OMNI Eligibility System and Necessary OMNI Terminal Downloads*, dated January 5, 2000

Providers are reminded that **any bulletin referenced in the list above is available on the Indiana Medicaid Web site at** www.indianamedicaid.com. If you have any questions about the information in this bulletin, please call EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.