January 13, 1998

To: All Medicaid-Enrolled Health Care Professionals

This is a reminder that, in accordance with Senate Enrolled Act. No. 184 of the 1997 Indiana General Assembly, Indiana Medicaid coverage of diabetes self management training services commences on January 1, 1998. A Medicaid bulletin specifying coverage and billing policies for diabetes self management training services is currently being finalized, and will be distributed just as soon as possible.

To: All Indiana Medicaid Providers

Effective September 13, 1996, Indiana Medicaid will not apply a site of service reduction differential for procedure codes 96105 (cerebral aphasia testing) and 96111 (cerebral development testing). In July 1996, Medicare changed the site of service indicator on the Medicare Fee Schedule Database from "1" to "0".

To: All Indiana Medicaid Providers using the HCFA-1500 claim form

In order to facilitate efficient processing of HCFA -1500 claim forms, it is critical that providers DO NOT staple the HCFA-1500 in the area marked "DO NOT STAPLE IN THIS AREA", at the top left corner next to the bar code. Also, DO NOT write or type any additional information at the top of the claim form next to the bar code. This area MUST be left blank for microfilming and assignment of the Internal Control Number (ICN).

If you are attaching a copy of an old claim to support waiving the one year claim filing limit, please draw a line across the page and turn it with the bar code at the bottom to avoid that claim being processed as a new claim. Your assistance is greatly appreciated.

To: All Indiana Medicaid Pharmacy Providers

This is to notify all Pharmacy Providers of a change to the Medicaid Drug Federal Upper Limit (FUL). The change is effective immediately. The following product has been deleted from the Medicaid FUL: Clofibrate 500 mg, Capsule, Oral, #100.

To: All Indiana Medicaid Pharmacy Providers

This is to inform all Indiana Medicaid Pharmacy Providers that there has been an issue with NDC/HRI/UPC's being priced inconsistently or denied unnecessarily. This problem was a result of NDC/HRI/UPC's being reused by the manufacturer. A code can be reused to represent a different product after being obsolete for three years. However, Indiana currently maintains the old pricing for the reused or duplicate products. A system change will be implemented to price drug claims and compound drug claims with the most current pricing based on the date of service for reused/duplicate codes received on or after January 16, 1998. As a part of the system change, a new edit, 4213, has been added to suspend paper claims to verify the code was keyed correctly. With this edit, electronic, POS and adjustment claims will systematically deny when submitted with codes that have been identified as invalid based upon the above criteria. If the claim denies, the provider should verify that the proper code was submitted on the claim. If you have identified claims that have paid inconsistently as a result of this problem, please submit an adjustment. If you have further questions, you may contact the Provider Assistance Unit at 1-800-577-1278 or locally at (317) 655-3240.

To: All Indiana Medicaid Providers

Effective December 24, 1997, Medicaid began accepting HCFA form 484 (5/97) as the Certification of Medical Necessity for Oxygen. This form was distributed by Medicare and is very similar to the form used previously by Medicaid.

To: All Indiana Medicaid certified Nursing Facilities and Intermediate Care Facilities (large and small)

Effective January 9, 1998, the Indiana*AIM* system will utilize the patient status code from the UB92 claim form STAT code box to close out the recipient level of care segment for selected discharge status codes. This code must indicate the status of the resident as of the ending service date of the period covered on the LTC claim. Indiana*AIM* will close out the recipient level of care segment for a recipient whose claim has one of the following Patient Status Codes: 01, 02, 05, 06, 07, 08 or 20. It is imperative that the NF or ICF/MR provider submit the correct patient status code. *Caution: If you are filing a claim for a resident on either hospital or therapeutic bedhold, DO NOT use a discharge status code on the claim form. The discharge status code will close the Recipient Level of Care segment and all future claims will deny for edit 2008, "Recipient ineligible for level of care billed".*

For any questions, please contact the EDS Long Term Care Review unit at (317) 488-5099.

To: All Indiana Medicaid Inpatient Hospital Providers

The Indiana*AIM* system has been modified to allow full DRG payment to transferring hospitals when a claim is grouped to a neonatal DRG. The modification was made on January 5, 1998. Neonatal DRG claims which were previously paid at the per diem rate will be mass adjusted to allow for the full DRG payment.

To: All Indiana Medicaid Providers

Edit 5008 has recently been implemented, which will prevent future crossover claims from paying multiple times. A mass adjustment is currently in process to recover overpayments previously made on these claims. Claims for which an adjustment has already been processed should not be affected.

To: All Indiana Medicaid Providers of Anesthesia Services

This is a correction to the December 23 and December 30, 1997 Banner Pages.

The QJ modifier was incorrectly placed on the line with CRNA services. QJ modifiers should only be used to identify the service of Medical Direction by an Anesthesiologist, not a CRNA. Correction follows:

CRNA's should always bill with a QX or QZ modifier. (AA Modifier is not necessary)

Example: Procedure Code 47600 Modifier QX or QZ.

Anesthesiologist billing for Medical Direction should use a QO, QQ or QJ modifier.

Example: Procedure Code 47600 Modifier QO, QQ or QJ.

To: All Indiana Medicaid Providers

Partial sterilization is billed using the same HCPC code as for complete sterilization. Providers billing partial sterilization are no longer required to obtain or submit a consent for sterilization form. However, "partial sterilization" MUST be noted on the face of the claim. Claims must be submitted on paper and no supporting medical documentation is needed.