March 3, 1998

To: All Indiana Medicaid Providers

Previously, crossover claims with modifiers 54 (Surgical Care only), and 55 (Postoperative Management only) were erroneously denying as duplicate claims. For example, when a crossover claim for a surgical procedure submitted with modifier 54 was paid prior to the claim with modifier 55 for the same surgical procedure, then the claim with the 55 modifier denied as a duplicate claim. The reverse also occurred. The system was fixed as of 10/10/97 and edit 5008 was updated to include instructions for processing crossover claims submitted with modifiers 54 and 55. EDS will not systematically reprocess these claims since most providers were submitting these claims for special batching. Further, reprocessing would generate a CCF for the Medicare EOMB. Providers need to resubmit erroneously denied claims with the Medicare EOMB. Crossover claims are not subject to the filing limit, so no documentation is needed to waive the filing limit.

To: All Indiana Medicaid Providers:

EDS is currently in the process of rewriting the Indiana Medical Assistance Programs Provider Manual. This process has involved input from various medical associations throughout the State of Indiana. Please note that this manual is still in the draft stage. Newly enrolled providers and providers requesting a new copy of the manual will receive the current version of the manual (dated October 1994). Upon completion of the manual rewrite project, EDS will forward a revised manual to all enrolled providers. Providers will be kept informed of the progress of this project in future banner page remittance advice articles.

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 was effective February 12, 1998. The following products have been deleted from the Medicaid FUL:

Lorazepam	0.5 mg. Tablet, oral, #100
Lorazepam	1.0 mg. Tablet, oral #100
Lorazepam	2.0 mg. Tablet, oral #100

To: All Indiana Medicaid Dental Providers:

On page 4 of Medicaid Update Bulletin E98-03, dated 1/16/98, the correct phone number for AVR is 1-800-738-6770 and the correct phone number for MaxiHealth member services in the central region is 1-800-401-6294. The numbers printed in the bulletin are incorrect. The reprocessing of denied claims as outlined in Bulletin E 98-03 dated 1/16/98 has been completed and the affected claims will appear on this week's Remittance Advice Statement. Dental claims with a control number beginning with 80 are those claims which were systematically reprocessed by EDS.

To All Indiana Medicaid Pharmacy Providers:

This is to inform all Pharmacy Providers of a mass adjustment that will be taking place to correct pharmacy claims that randomly paid inappropriately. NDC 00083-0027-30 is a NDC that has been reused by the drug manufacturer Novartis. The NDC was previously used for Progestamate 10mg tablets. The manufacturer of this product reused this NDC for Tegretol 200mg tablets. With the same NDC on file for two different drugs, pharmacy claims would randomly pay at the correct price for Tegretol 200mg and randomly pay inappropriately for Progestamate 10mg. EDS implemented edit 4213 in January, 1998 to resolve this problem. Claims have been identified that paid at the Progestamate 10mg pricing with dates of service 1/1/97 to 1/23/98 and are being adjusted systematically to pay at the higher Tegretol 200mg pricing. Providers will see this adjustment on their weekly RAs.

An Important Reminder To All Indiana Medicaid Providers:

No person or persons shall, on the grounds of race, color, national origin, handicap*, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program, service or benefit advocated, authorized or provided by this Office.

* Note: Section 504 of the Rehabilitation Act of 1973 protects individuals with AIDS and individuals with asymptomatic HIV infection as "qualified handicapped persons."

To: All ICF/MR and Psychiatric Hospital Providers:

This is to advise you that the Balanced Budget Act of 1997 (BBA) has eliminated the requirement for periodic inspections of care for each Medicaid beneficiary receiving services in an intermediate care facility for the mentally retarded (ICF/MR) or in a psychiatric hospital. The states' responsibility for assuring appropriateness of reimbursement and compliance with other program requirements has not been eliminated. As a result of this change, the OMPP has immediately discontinued all ICF/MR facility and psychiatric hospital audits scheduled by the EDS inspection of care teams. OMPP is now working with the Health Care Financing Administration (HCFA) to reevaluate and redirect the audit function in the ICFs/MR. OMPP will notify ICF/MR providers promptly once the new audit function is defined and ready to be implemented. If you have any questions, please contact the EDS Long Term Care Unit at (317) 488-5099.

To: All Medicaid Providers of Long Term Care (Nursing Facilities, Community Residential Facilities for the Developmental Disabled, ICF/MRs)

Effective 3/1/98, the Personal Needs Allowance (PNA) as reflected in 405 IAC 2-3-17 and 2-3-21 has been changed. The PNA has been increased from $30 or $35 for all Medicaid recipients residing in long term care facilities who DO NOT receive SSI. As you are aware, the PNA is the amount of money which the recipient is allowed to keep in order to buy personal items. As a result of this change, the patient liability amount paid to the facility by Medicaid recipients residing in your facility may not have changed. Please check with each of your residents in order to ascertain the appropriate personal liability to be applied on 3/1/98. All recipients affected by this change have been notified in writing of the decrease in their personal liability amount. Each resident should be able to provide you with a copy of that notification for your reference.

It is important to remember that the decrease in a patient's personal liability amount does not constitute any changes in the billing practices already employed by your facility. The Indiana *AIM* system will automatically deduct each patient's new liability amount at the time the claim is being processed based on liability amount information provided by the county offices.

If you have any questions relative to this change, please contact EDS Provider Assistance at 1-800-577-1278 or 317-655-3240.

To: All Indiana Medicaid Providers

Some recent Remittance Advice Statements have reflected an incorrect amount for DRG. However, the amount paid was correct. EDS is researching the problem and will generate new Remittance Advice Statements once the correction is made. Watch future banner pages for more information.