October 6, 1998

To All Indiana Medicaid Nursing Facility Providers:

This is to clarify the use of the Form 450B pending the development of the new cover form "450B Data Entry/Authorization Sheet", addressed in the Case Mix Reimbursement Provider Bulletin E98-26 of August 14, 1998. The new form documented under the section entitled "Form 450B/Nursing Facility Level of Care" on page two (2) is a streamlined type Form 450B. For **dates of service on or after October 1, 1998**, the new 450B Data/Authorization Sheet may be used for any readmission to a nursing facility following a hospitalization exceeding the bed-hold policy if the Medicaid resident has already been approved for nursing facility care. This new form is not yet available to nursing facilities. As a result, facilities should continue to use the current Form 450B for submission to the Office of Medicaid Policy and Planning. However, **only Section I "Recipient Identification" needs to be completed, along with documentation of the dates of the hospitalization.** Leave the entire Section II "Physician's Medical Evaluation" blank. Likewise, the physician does not need to complete or sign the "Level of Care Physician Certification". Please write READMISSION in red ink in the top left-hand corner of the Form 450B in order to ensure that the data entry of these readmission requests is expedited. Please note that additional information will be forthcoming regarding expanding the use of the new 450B Data Entry/Authorization Sheet to streamline other Form 450B processing following the implementation of case mix reimbursement.

To All Indiana Medicaid Nursing Facility Providers:

Due to the system changes required for the implementation of the case mix reimbursement system, please do not bill for a date of service span overlapping the September 1998 to October 1998 date range. Please bill all September 1998 and preceding dates of service separately from October 1998 and subsequent dates of service. If a claim is received for dates of service overlapping between September 1998 and October 1998, the claim will deny for edit 2008 "recipient not eligible for level of care". Example: Claim submitted with DOS 9/28/98 - 10/04/98 will deny for edit 2008. This is due to the conversion of the recipient level of care indicators from the level of care reimbursement ending with date of service September 30, 1998 to case mix reimbursement beginning with date of service October 1, 1998. No future date of service timespans will be affected by this change.

To All Indiana Medicaid Providers:

Effective October 1, 1998, the new ICD-9-CM diagnosis and procedure codes were loaded into the Indiana*AIM* system. However, until the 3M Diagnosis and Procedure Code mapper is installed to the Indiana*AIM* system, claims submitted with the new ICD-9-CM procedure codes will deny for EOB 4116 ("diagnosis is not valid for DRG pricing"). Once the mapper is installed, EDS will systematically reprocess all denied claims. Future banner messages will keep providers informed of the reprocessing date. A banner page message will be forthcoming to inform providers of the end date for the deleted codes.

To All Indiana Medicaid Providers:

This is to notify all Indiana Medicaid Providers that **effective October 1, 1998**, all overpayments, accounts receivable, and check related refunds should be mailed to the new lockbox address. Checks should be made payable to EDS and/or Indiana Medicaid. Please send checks to:

EDS
P.O. Box 1937 Dept. 104
Indianapolis, IN 46206

Payments submitted with purchase requests for the Indiana Medical Assistance Programs Provider Manuals, Max Fee Schedules, NECS Software, and copies of remittance advice statements should be sent to:

EDS
Attn: Mica Oakley
950 North Meridian Street - 9th Floor
Indianapolis, IN 46204

EDS Provider Payment Checks that are being returned to EDS (for example, checks to be voided, sent to wrong address in error, duplicate payments, not your patient or doctor. etc.) should also be forwarded to the 950 North Meridian Street, 9th Floor address.

To: All Risk Based Managed Care Providers

Effective 07-01-1998, MaxiHealth for the Southern Region of the State of Indiana has a **new** Member Services phone number. The **new** phone number is 1-800-414-5946. Currently the AVR system identifies the Central Region number but will be updated to indicate the new number for the Southern region.

To All Indiana Medicaid Hospital Providers:

This message is to clarify the billing of outpatient self-administered drugs for dually eligible recipients. For Medicaid recipients, most drug and supply revenue codes are denied if billed in conjunction with one of the treatment room revenue codes for outpatient services. This includes self-administered drugs for which reimbursement is included in the treatment room allowance for Medicaid only recipients. Currently, for dually eligible recipients, Medicaid pays the co-insurance and deductible, but does not cover self-administered drugs that are not covered or payable by Medicare. Therefore, for Medicaid recipients also covered by Medicare on the date of outpatient treatment room services, the cost of self-administered drugs may be billed to Medicaid on the Indiana Medicaid Pharmacy Claim Form. Providers must utilize their separate Indiana Medicaid Pharmacy provider number for billing, or obtain a number if necessary by contacting the EDS Provider Assistance Unit at 1-800-577-1278. If there are questions as to filing claims utilizing the Medicaid Drug Claim Form, these can be addressed to Provider Assistance as well. **Please Note: Billing of self-administered drugs for Medicaid recipients who are not also covered by Medicare is not appropriate.**

To All Indiana Medicaid Providers Billing for Co-pay and Deductibles for Recipients Enrolled in Private HMOs:

Medicaid will reimburse providers for co-pays and deductibles, and services not covered by the plan incurred by Medicaid recipients under a capitated arrangement. When billing for co-pays and deductibles, the provider should indicate the amount of the total bill covered by the HMO in the TPL box such that the net charge billed to Medicaid is only the deductible and co-pay. Medicaid will reimburse the provider the difference between the Medicaid allowable and the TPL amount, not to exceed the net billed amount.

To All Indiana Anesthesia Providers:

This banner page notification is written to inform providers that EDS has corrected the processing problem identified for claims submitted for epidural maternity services. Effective August 31, 1998, anesthesia pricing logic was corrected according to guidelines stipulated in Bulletin E95-21 which states that "Providers billing anesthesia services for a vaginal or Cesarean delivery should use the CPT 4 procedure code which best describes the service provided plus the modifier (AA). Procedure codes 59409, 59410, 59514, and 59515, should be reimbursed as: one unit of time for each 15 minute block of time billed in the first hour of service, and for subsequent hours of service calculate one unit of service for every 60 minute block of time billed."

EDS will systematically reprocess all claims adversely affected by this processing problem; therefore, providers are not required to resubmit their claims. EDS will alert providers of the reprocessing of these claims by banner page notification 45 days prior to this reprocessing function.

Please note: EDS has identified claims that were inappropriately paid after August 31, 1998. EDS is working to resolve this problem and will mass adjust those claims affected. The date of the mass adjustment will be published in a future banner page.