December 8, 1998

To All Indiana Medicaid Enrolled Hospice Providers:

The Indiana Medicaid Program cannot prior authorize any services for an individual who is not Medicaid eligible. An individual who is NOT Medicaid eligible when he/she initiates hospice care is considered "private pay". This means that the hospice provider must bill the patient or the patient's private insurance (if applicable) until Medicaid eligibility is established. If hospice providers opt to provide hospice care for a Medicaid pending individual, hospice providers do so at their own financial risk. As the hospice analyst cannot review and approve the certification forms for a Medicaid pending individual, the hospice provider should hold all paperwork until the Medicaid pending individual is notified that he/she is Medicaid eligible. At that point, the hospice provider may submit the certification forms to the EDS Hospice Authorization Unit (effective January 1, 1999, the certification forms must be submitted to the HCE Hospice Authorization Unit). The ten (10) day submission rule for certification forms does not apply for Medicaid pending individuals. However, once a hospice patient becomes Medicaid eligible, the hospice provider must submit the certification forms within the ten (10) business day deadline noted in the hospice rule. The Medicaid Hospice Analysts have been instructed to return to hospice providers all certification forms for Medicaid pending individuals. This is in compliance with policy for all Medicaid programs.

To All Indiana Medicaid Enrolled Physicians:

In response to inquiries regarding how to bill for an FDA approved immunization when there is no corresponding CPT code, the following is recommended. Providers should submit a HCFA 1500 claim form using procedure code 90749, "unlisted immunization procedure", the number of units given, and the provider's usual and customary charge. The NDC from the package should also be listed on the claim. No invoice is required. The claim reviewer will use the average wholesale price for the NDC and add a $2.90 administration fee for the immunization.

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

Effective October 1, 1998, the Indiana*AIM* system will pay the per diem rate on file for all long term care claims with a date of service on or after October 1, 1998. This change will ensure that payment made to the provider reflects the most current rate received by EDS from Myers and Stauffer, rather than an old rate that the provider may have billed. This revised payment mechanism should assist in minimizing the number of retroactive rate adjustments for dates of service on or after October 1, l998. The payment logic for long term care claims with dates of service prior to October 1, 1998 will continue to pay the provider the lesser of the billed amount or the per diem rate on file. For any questions regarding the information contained in this banner message, please contact the EDS Provider Assistance Unit at 1-800-577-1278, or for local providers (317) 655-3240.

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 Acute Care Hospitals, Distinct Part Psychiatric Hospitals, Rehabilitation Hospitals, Distinct Part Unit Psychiatric Facilities, and Ambulatory Surgical Centers: In the future, the Office of Medicaid Policy and Planning (OMPP) plans on updating and making changes to both the DRG/Level of Care inpatient and outpatient reimbursement systems. Public notice of the intent to change the methods and standards for setting payment rates for inpatient services was provided on the September 1, 1998 and October 1, 1998 versions of the Indiana Register. A bulletin will be sent to providers detailing the changes and new rates to be implemented for reimbursing Indiana Medicaid inpatient and outpatient services. Billing procedures for both inpatient and outpatient hospital services have not changed. However, as a result of rebasing and updating the DRG system, the Grouper version will need to be updated. The All-Patient (A-P) DRG Grouper Version 11 is currently being used as the Grouper for the DRG system in Indiana. As with the Medicare Grouper, new versions of A-P DRG Grouper are issued periodically. Revised versions of the grouper software are not adopted by the State until the DRG system is rebased or you are notified by the State. At that time, the State upgrades to the most current version of the Grouper. Therefore, as a result of rebasing the DRG system, the State will upgrade to the most current version of the Grouper. With the implementation of the rebased DRG system, Indiana Medicaid will utilize Version 14.1 of the A-P DRG Grouper. While OMPP intends to give providers thirty (30) days advance notice before implementing the new rates, OMPP thought providers might need additional lead time to obtain the Grouper software, in the event you elect to purchase same. If you are interested in ordering a copy of the Grouper, and have a license with 3M you may contact 3M at 1-800-435-7776. If you do not have a license with 3M, call 502-473-7043 or HSS at 1-800-999-3747 to obtain information about Version 14.1 of the A-P DRG Grouper. **Please note:** The new rates for both the inpatient and outpatient reimbursement systems will become effective and be implemented simultaneously. The purpose of providing public notice through the Indiana Register was to allow the public and hospital providers the opportunity to provide comments on the rate and weight changes. The effective date described in the Indiana Register was used as the cut-off date for the public to provide those comments and as a target effective date. Hospitals will be given thirty (30) days notice before the new rates for inpatient and outpatient services become effective and are implemented. Once implemented, the new rates for both services will be prospectively applied.

To All Indiana Medicaid Pharmacy Providers:

The following labeler has entered into a drug rebate agreement and is joining the rebate program effective January 1, 1999:

Boca Pharmacal, Inc. (Labeler Code 64376)

The following labeler has been reinstated into the drug rebate agreement effective January 1, 1999: Consolidated Pharmaceutical Group (Labeler Code 61423)

The following labeler is being voluntarily terminated effective January 1, 1999: Pharmaderm, Div. Of Altana, Inc. (Labeler Code 00462)