IMPORTANT INFORMATION

BR200208 FEBRUARY 19, 2002

To All Providers:

- The Indiana Health Coverage Programs (IHCP) is pleased to announce Web interChange – an interactive Web application to obtain claims information and verify member eligibility quickly and easily using the Internet.
  - Claims Inquiry allows providers to inquire about previously submitted claims. Claims received electronically by EDS are Web accessible within two hours and remain accessible for three years. Claims are located by searching within a date range, by claim type, by member ID, or by Internal Control Number (ICN). Once the basic claim information is displayed, click the desired claim for more detail.
  - Eligibility Inquiry allows providers to inquire about member eligibility by using search criteria. The response provides the same information found through Automated Voice Response (AVR), Provider Electronic Solutions^{SM}, or the OMNI swipe card system. Enhanced third party liability information including carrier number, carrier name, addresses, phone number and policyholder name is also provided.

  Web interChange differs from Provider Electronic Solutions because with Provider Electronic Solutions providers submit claims and verify member eligibility by dialing into the IHCP system; but with Web interChange providers can review processed claims and verify member eligibility by accessing the IHCP system on the Internet. Web interChange is fast, free, easy to use, and does not require special software. Microsoft® Internet Explorer 5.5 or above is required. It is not necessary to have Provider Electronic Solutions to use Web interChange. Web interChange is secure. Only billing providers may access claims. Encryption and Secured Socket Layer (SSL) connections protect the data in transit.

  To apply for an ID and password, complete the application found at https://interchange.indianamedicaid.com. Print and mail the application to the address shown. Be sure to keep a copy for your records. You will be notified via e-mail when your application is approved. Direct questions to EDS Electronic Solutions at (317) 488-5160 or e-mail *Electronic.Solutions@indyxix.eds.com*.

- The 2002 *Health Care Procedure Coding System* (HCPCS) and CPT code updates were loaded for crossover claims only on January 1, 2002. Providers should continue billing 2001 codes until April 1, 2002. The IHCP will deny claims submitted with 2002 codes for dates of service prior to April 1, 2002. Questions can be directed to the Health Care Excel (HCE) Medical Policy Department at (317) 347-4500.
- Following is an update to an article originally printed September 25, 2001, in *BR200139*.

  Edit 0232 – Rendering physician number is not in valid format, was inactivated for all crossover claims on July 7, 2000. EDS identified some duplicate claim payments made after that date. *Edit 0232* was reactivated effective September 14, 2001, to prevent additional duplicate payments. A systematic mass adjustment was finalized January 15, 2002, to recoup affected claims paid from July 7, 2000, through September 14, 2001. The adjustments denied because the Medicare information was not on file at the time of original claim adjudication. EDS is reviewing all crossover claims denied for *edit 0232* during this mass adjustment. If the correct Medicare information is now on the provider file, EDS will systematically reprocess the claim. Claims identified for reprocessing will appear on the RA dated February 19, 2002.

  If EDS does not have the correct Medicare information on file for both rendering and billing providers, the denied adjustments will not be reprocessed. The provider must resubmit the crossover claim on paper or by using Provider Electronic Solutions. Additionally, future claims received from Medicare will not automatically crossover for Medicaid adjudication.

To All Long Term Care Providers:

- Effective January 8, 2002, the color of paper used for the Indiana Pre-Admission Screening Program (PAS/PASRR) Assessment Determination State Form 707 (R/2-98)/Form 4B changed from blue to beige because the U.S. Postal Service machines no longer read the paper color. Applicants and nursing facilities will now receive the PAS Form 4B on beige paper.

To All Physicians, Nurse Practitioners, Clinics, Federally-Qualified Health Clinics, and Rural Health Clinics:

- Effective February 1, 2002, the $2.90 administration fee included in office administered injectable drug codes was removed. Exemptions to this revised policy include vaccines and toxoids that continue to include the $2.90 administration fee. Refer to bulletin *BT200151* for details about this revised policy.

To All Home Health Providers:

- This clarifies the information that must be submitted with a written prior authorization (PA) request for home health services, or that can be requested as written documentation to supplement telephone requests for PA. According to *405 IAC 5-16-3,* the following information must be submitted:
  - Estimate of the costs for the required services as ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician. The cost estimate must reflect the cost estimate of each service, plus the overhead rate for the time period requested, on the plan of treatment.
  - Caregiver(s) available to provide care for the member including consideration of whether the caregiver works outside the home or attends school outside the home. A copy of the caregiver's work schedule from the employer or the class schedule from the school must be submitted with the PA request.
  - Whether the member works or attends school outside the home including what assistance is required. A list of service currently provided service hours in the home. For example, services provided through CHOICE, Waiver, or others.

  Refer questions to the HCE PA Department at (317) 347-4500.

To All Nursing Facilities and Hospice Providers:

- The Marion County Superior Court ruled against the Office of Medicaid Policy and Planning (OMPP) in a lawsuit filed by Amhealth challenging the OMPP for imposing emergency rules as of October 1, 2001. The Court's ruling prevents the OMPP from carrying out these rules as of October 1, 2001; however, be advised, the OMPP intends to implement the rules on a permanent basis on or about April 1, 2002. These rules change the case mix reimbursement methodology, reimbursement policy for bedhold days for nursing facilities, hospice recipients residing in nursing facilities, and crossover claims payment policies. The Court's decision prohibits the OMPP from enforcing the provisions of the emergency rules and requires that the OMPP reprocess all claims submitted by nursing facilities resulting from the implementation of the emergency rules.

  The OMPP is determining what actions need to be taken to comply with the court's decision. Decisions include, but are not limited to, systems changes as well as rate recalculations. The OMPP must ensure compliance with the court order is done in an orderly and uniform fashion. Additional information and billing instructions will be published in a future provider bulletin.

  Direct questions about this information to EDS Customer Assistance at (317) 655-3240 in the Indianapolis area or 1-800-577-1278 outside the Indianapolis area.

To All Dental Providers:

- Bulletin *BT200003*, published January 14, 2000, clarified the policy for coverage of dentures and partials. The **Prior Authorization of Dentures and Partials** section, under **Exclusions and Limitations** states the following:

  > **Relines and Repairs – Laboratory relines** (D5750-D5761), **repair to dentures** (D5510 and D5520) and **repairs to partial dentures** (D5610-D5660) are covered only when the reline or repair will extend the useful life of a medically necessary denture or partial that is six (6) or more years old. PA is required for adults. In order to be approved, the PA request should indicate the individual is eligible for a new prosthesis, but a repair or reline will extend the useful life of the existing prosthesis.
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  > **Partials for Replacement of Anterior Teeth Only** – Requests for partial dentures that replace anterior teeth only will not be approved. Anterior tooth replacement will be considered purely an aesthetic or cosmetic concern and not medically necessary.

  According to *BT200003,* the IHCP will not approve or pay for repairs to partial dentures not meeting the guidelines nor will repairs to anterior teeth of partial dentures for adults be reimbursed. The bulletin is available on the www.indianamedicaid.com Web site. Direct questions to the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis area and 1-800-577-1276 outside the Indianapolis area or contact the HCE Medical Policy Department at (317) 347-4500.

- *Z5155, SQ/IM/oral administration of sedation and monitoring* will be end-dated and made non-covered effective March 29, 2002. This code was replaced by dental procedure code *D9248*, (non-intravenous conscious sedation) effective for dates of service January 1, 2000, and later. Non-intravenous conscious sedation includes appropriate monitoring, as defined by the *Current Dental Terminology (CDT-3) Users Manual,* version 2000, published by the *American Dental Association*.