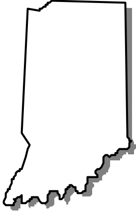

I M P O R T A N T   I N F O R M A T I O N

BR200233 AUGUST 13, 2002

To All Providers:

- Bulletin *BT200245* will be forthcoming to inform providers of submission changes for Medicare Part A, Part B, and Part C crossover claims. This bulletin will be posted on the Indiana Health Coverage Programs (IHCP) Web site at http://www.indianamedicaidcom/ on Tuesday, August 13, 2002.

- The Indiana State Department of Health announces that effective September 1, 2002, the vaccine for diphtheria, tetanus, and pertussis (DTaP) will be available through the Vaccines for Children program. Therefore, for dates of service on or after September 1, 2002, reimbursement for Health Care Procedure Coding System (HCPCS) code *90721*, is the lesser of the $8 administration fee or the billed amount.

- Effective August 15, 2002, all UB-92 crossover claims must contain additional information on the claim form, due to Family and Social Services Administration (FSSA) Emergency Rule *LSA #02-121* that changed the way all Medicaid providers are reimbursed for crossover claims. The information in the required fields on the UB-92 claim form will be used to process claims after the system changes are in place. Fields 39 through 41 of the UB-92 claim form must contain value code *A1* to reflect the Medicare deductible amount; value code *A2* to reflect the Medicare coinsurance amount; and value code *06* to reflect the blood deductible amount.

  To ensure correct reimbursement, field 50A of the UB-92 claim form must now show Medicare as the payer. Additionally, field 54A must contain the Medicare paid amount (actual dollars received from Medicare). Do not include the Medicare allowed amount or contract adjustment amount in field 54A. UB-92 crossover claims submitted without this information will deny. Third party liability payments continue to be reported in field 54B.

  Inpatient crossover claims (claim types *110, 111*, and *115*) must be submitted on the UB-92 claim form and must contain all of the information necessary to establish a diagnosis-related group for pricing. Continue to submit a Medicare Remittance Notice (MRN). This change renders the *Crossover Short Form* and Provider Electronic Solutions[SM] obsolete for inpatient crossover claims. Effective August 15, 2002, inpatient crossover claims submitted on the *Crossover Short Form* will be returned to the provider. Inpatient crossover claims submitted on Provider Electronic Solutions will be denied.

  The Medicare denial process will not change. Medicare denied charges should still be submitted to the applicable claims address and must include the MRN for the denied charges. These changes are being implemented to comply with the new crossover

reimbursement policy announced on May 28, 2002, in banner page *BR200222*. Additional information about these changes will appear in a future IHCP bulletin.

- The Academy of Pediatrics, in conjunction with the Indiana Parent Information Network, Inc., and Riley Hospital for Children will hold the *Every Child Deserves a Medical Home* training October 5, 2002, in Indianapolis.

  The target audience for this training session includes pediatric health professionals and their staff, other professionals, families, managed care professionals, policymakers, community members and other advocates who care for children with special needs. Continuing medical education units and other continuing education credits are available from this training session. For more information or to register contact Linda Hankins, Community Education and Child Advocacy Department, Riley Hospital for Children at (317) 274-6939 or send an e-mail to lhankins@iupui.edu.

To All Waiver Providers:

- The Office of Medicaid Policy and Planning (OMPP) has established a review process for the Indiana Health Coverage Programs (IHCP) Home and Community Based Services (HCBS) Waiver Programs. EDS performs waiver provider reviews on a schedule approved by the OMPP. This process initially included developmentally disabled waiver providers only. Effective September 1, 2002, the review process will expand to additional waiver providers or waiver services as approved by the OMPP. Providers will be notified prior to the commencement of the review.

  The EDS review team is responsible for the following items:
  - Examining the member's current approved plan of care, and related documentation of the case manager and provider.
  - Verifying the delivery of services billed to the IHCP.
  - Meeting with a sample of members in the home to ensure services meet the needs of the member, and to review the member's eligibility for waiver services.
  - Reviewing provider staff training plan and staff training hours.
  - Reviewing provider qualifications and the qualifications of the field staff.

  When the review is complete, an exit conference is held to discuss the review findings. The exit conference provides an opportunity to share information and provide education. Further development of the review process will be based in part on the information gathered during these reviews.

  EDS appreciates provider cooperation and patience during this time of development as Indiana seeks to improve the IHCP HCBS Waiver Programs.

CDT-3/2000 (including procedure codes, definitions (descriptions) and other data) is copyrighted by the American Dental Association. © 1999 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation System/Department of Defense Acquisition Regulation System (FARS/DFARS) Apply.

CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.