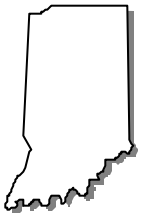


IMPORTANT INFORMATION

BR200242 OCTOBER 15, 2002

To All Physicians:

- On October 7, 2002, EDS performed a system modification that affects surgical claims billed on the HCFA-1500 with the cosurgeon modifier 62. As stated in the *Indiana Health Coverage Programs (IHCP) Provider Manual*, Chapter 7, providers who bill as cosurgeons must append modifier 62 to the surgical service. The IHCP allowable amount is calculated at 62.5 percent of the resource-based relative value scale (RBRVS) IHCP Fee Schedule. Prior to October 7, 2002, the allowed amount for claims billed with the modifier 62 was calculated at 100 percent of the RBRVS IHCP Fee Schedule, resulting in overpayments. EDS will perform a systematic mass adjustment of all claims in a paid status billed with modifier 62. Claims mass adjusted will appear on the December 3, 2002, remittance advice.

To All Providers:

- EDS requests that providers not staple, paper clip, or physically attach in any way claims to their attachments. Not stapling or paper clipping allows claims to process more effectively and efficiently.
- Providers wishing to file for a one-year extension to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Health Care Transactions and Code Sets Standards Compliance Act must do so no later than October 15, 2002. Visit the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.hhs.gov/hipaa to print the form or complete the compliance plan electronically.

  Compliance plans must be submitted electronically or be postmarked no later than October 15, 2002. After October 15, 2002, compliance plans received electronically by CMS or paper compliance plans postmarked after this date will not receive an extension. Detailed instructions about the steps to file for the extension are also available on the CMS Web site.

  Note there is no extension for the HIPAA Privacy Rule compliance. Privacy Rule compliance is effective April 14, 2003.
- This is a correction to Indiana Health Coverage Programs (IHCP) provider bulletin *BT200250—End-dating and Limitations of Dental Codes*. This bulletin incorrectly lists D9240 for the hospital service call. The correct code for a hospital service call is D9420. This code is not covered effective November 1, 2002.
- Effective October 1, 2002, the new *ICD-9-CM* diagnosis and *ICD-9-CM* procedure codes are in Indiana*AIM*. The new codes should now be used for all HCFA-1500 claims. However, the system processing components for pricing and editing are **not yet** complete for these new codes. Therefore, **inpatient claims** submitted with the new codes will deny for explanation of benefit (EOB) code *4116–Diagnosis code is not valid for DRG pricing*. Upon completion of the component linkage, EDS will systematically reprocess all **inpatient claims**, and the reprocess date will be published in a future banner page article. Direct questions to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To All Mental Health Providers:

- On October 2, 2002, EDS performed a system modification affecting Medicare Part B crossover claims billed by a health service provider in psychology (HSPP) with an AH modifier appended to a Health Care Procedure Coding System (HCPCS) code. Paper and electronic Medicare Part B crossover claims will now calculate the claim allowance at 100 percent of the IHCP fee schedule amount when an HSPP is the rendering practitioner. All other claims billed with the AH modifier appended to a HCPCS code and submitted by a rendering provider specialty other than the HSPP will calculate the IHCP allowed amount at 75 percent of the IHCP fee schedule. For example, if a psychiatrist's provider number is entered in the rendering field locator (24K) and either the AH or AJ modifiers are appended to a HCPCS code, the system will calculate the IHCP allowed amount at 75 percent of the IHCP fee schedule.

On October 3, 2002, EDS systematically mass adjusted all Medicare Part B claims billed with a rendering provider specialty of HSPP with a date of service from July 1, 2002, through October 2, 2002. All mass adjustments should appear on the October 16, 2002, remittance advice.

To Durable Medical Equipment and Pharmacy Providers:

> *Note: The information referenced below is not directed to those providers rendering services in the risk based managed care (RBMC) delivery system.*

- In banner page, *BR200106*, dated February 6, 2001, providers were reminded of a policy in effect since August 1994 that medical supplies, non-medical supplies, and routine durable medical equipment (DME) items cannot be billed to the IHCP for members residing in a long term care facility such as nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and community residential facilities for the developmentally disabled (CRFs/DD). The cost for these services is included in the facility per diem rate. An analysis of claims was done to determine inappropriate payment. A mass adjustment is scheduled for November 19, 2002, for the providers that billed for medical supplies, non-medical supplies, and routine DME items provided to members in long term care facilities. This mass adjustment will appear on the November 26, 2002, remittance advice. Direct questions about this information to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

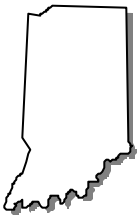
To All Certified Nursing Facilities:

- This updates IHCP-certified nursing facilities about the requirements for minimum data set (MDS) supportive documentation. Supportive documentation for all MDS data used to classify nursing facility residents in accordance with the Resource Utilization Group (RUG) III resident classification system, must be routinely maintained in each resident's medical chart.

  Effective on or after October 1, 2002, for all MDS assessments with an A3a date, the EDS Long Term Care review team is required to substantiate, for the following MDS elements, the frequency of occurrences coded:

MDS 2.0 Version 5.12, 34 -- Grouper			
Element Listing of RUG Items			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
E1a-p (pages 3-58 to 3-60)	Indicators of depression, anxiety, sad mood (1 of 2)	Examples of verbal or non-verbal expressions of distress; that is, depression, anxiety, and sad mood must be found in the medical chart irrespective of the cause. See MDS (E1) for specific details.	NN, SSN, SN, NR, CP
E4a-e **Col. A** (pages 3-62 to 3-65)	Behavioral	Acknowledgement and examples of the resident's behavior symptom patterns must be provided in the medical chart. The record must reflect the frequency of the behavioral symptoms manifested by the resident.	NN, SSN, SN, NR, CP
N1a, b, c (page 3-141)	Time awake (total checked equal 0 or 1)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer.	NN, SN, PPN, CP, SSN, NR, CNAN

Indiana Health Coverage Programs



I M P O R T A N T C R O S S O V E R U P D A T E

O C T O B E R 1 5 , 2 0 0 2

To All Providers

- Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200245*, dated August 13, 2002, stated Medicare Part A and C crossover claims would be released on October 1, 2002. To ensure all claims process according to current policy, additional review of claims is necessary. Therefore, the release of Medicare Part A and C claims will occur the week of November 4, 2002.
- In addition, *BT200245* also stated that as of August 15, 2002, all paper crossover claims must be submitted on the original red UB-92 claim form. Although the original red UB-92 claim forms are preferred, EDS will accept laser or computer generated claim forms. All claim forms must be clear and legible to ensure proper imaging and character recognition.
- Medicare Part B claims submitted with unlisted, unspecified, or miscellaneous codes must be submitted on paper with the proper documentation to support the cost of the item. Refer to the *IHCP Provider Manual*, Chapter 8, for acceptable documentation to support an item's cost. Electronic Medicare Part B crossover claims that contain a Health Care Procedure Coding System (HCPCS) code that requires manual pricing will systematically deny for EOB *9008– Line item submitted with unclear itemization. Please resubmit with appropriate or additional information. Electronic Medicare Part B claims submitted for services that require manual pricing must be billed on paper with an itemized cost invoice.*
- As a reminder, claims submitted for services covered by Medicare under a different HCPCS code than allowed by the IHCP will deny for EOB 4021 – *Procedure code is not covered for the date of service, for program billed. Please verify and resubmit;* EOB *4013 – This procedure code is not covered for this date of service;* EOB *4014 – No pricing segment is on file;* EOB *4033 – The modifier used is not compatible with the procedure code billed. Please verify and resubmit;* or, EOB *4209 – No matching pricing segment for the procedure or modifier combination billed on the HCFA 1500 claim form. Please refer to the provider procedures manual for the appropriate use of the modifiers TC, 26, RR, and NU.* Services in these categories may include, anesthesia care billed with the ASA codes and durable medical equipment (DME) items submitted with K codes and some G codes. Impacted Medicare Part B claims must be submitted on paper with the proper IHCP covered HCPCS code.
- EDS performed an extensive analysis of electronic Medicare Part B claims for mental health services rendered by a health service provider in psychology (HSPP). It was discovered that in some instances electronic Medicare Part B claims reflect the provider's group number as both the billing, *Field 33*, and rendering, *Field 24K*. This happens when both the individual provider rendering Medicare number is linked to the group's IHCP provider number. In the event the group provider number does not contain a provider specialty of 114-HSPP, claims billed with the AH modifier will calculate the IHCP allowance at 75 percent of the IHCP Fee Schedule amount. EDS Provider Enrollment is reviewing provider files that have individual rendering provider number(s) loaded incorrectly. EDS will contact each provider directly to verify and make changes necessary to correct the file. When all enrollment files are updated, EDS will perform a systematic mass adjustment for all claims billed with the AH modifier, that previously calculated the IHCP allowed amount at 75 percent instead of 100 percent for HSPP performed services.

- Ambulatory Surgery Center (ASC) claims that crossover from Medicare currently calculate the IHCP allowable amount based on the IHCP Fee Schedule for physicians instead of using the ASC pricing logic. System modifications will be implemented that allow Medicare Part B claims, submitted by provider type 02 and specialty 020 (ASC), to calculate the claim allowance based on normal ASC pricing. When the system modification is complete, all Medicare Part B claims billed by an ASC provider type and specialty will be systematically mass adjusted. Monitor future banner page articles for details about this issue.
- Medicare Part B coverage is available for routine service and maintenance of DME items. Claims submitted with the MS modifier append to the HCPCS code to denote the claim is for routine maintenance of the item. IHCP policy is that routine maintenance or repairs for items still under warranty are noncovered services. However, IHCP policy dictates that Medicaid must cover services allowed by Medicare. Therefore, EDS is developing a pricing methodology that allows the system to calculate an IHCP allowed amount to be used for Medicare Part B crossover claims only. When this pricing methodology is developed, EDS will systematically reprocess all Medicare Part B claims billed with the MS modifier and a date of service on or after July 1, 2002. Monitor future banner page articles for details regarding this issue.
- To ensure proper reimbursement for Federally Qualified Health Center (FQHC) and rural health clinic (RHC) providers, the July 1, 2002, Medicare/Medicaid crossover pricing methodology for provider type 08 and provider specialty 080 and 081, will be modified to allow the full Medicare coinsurance and deductible. EDS will perform the necessary system modifications the week of October 14, 2002. Medicare Part B claims impacted by this modification will systematically mass adjust the week of October 28, 2002. The system modifications will be in place for the November release of Medicare Part C claims; therefore, a mass adjustment is not required.
- EDS is in the process of making modifications to the remittance advice (RA) for Medicare Part A, B, and C claims. When the modifications are complete, the RA will display the following additional information for Medicare Part B and C claims:
  - All line item details
  - IHCP allowed amount for all line item details
  - Medicare paid amount
  - Total IHCP allowed for the claim
- The following additions will be made for Medicare Part A claims:
  - Diagnosis related grouping (DRG)
  - Medicare paid amount
  - IHCP total allowed for the claim
- The following item will be removed from the Medicare Part A claims:
  - Admit date