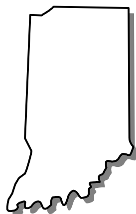

IMPORTANT INFORMATION

BR200246 NOVEMBER 12, 2002

To All Dental Providers:

- This reminds providers that the Indiana Health Coverage Programs (IHCP) bulletin, *BT200250*, dated September 15, 2002, notified dentists billing for prophylaxis and fluoride provided on the same day to children from one to 12 years old, that effective for dates of service on or after November 1, 2002, providers should bill with *D1201 – topical application of fluoride-child which includes prophylaxis*. The rate for D1201 is $47.75. For children and adolescents 13 to 20 years old, providers should bill D1205 when billing for prophylaxis and fluoride on the same day. The rate for D1205 is $61.

  BT200250 also notifies providers of a 50 percent reduction in dentures and partials. If a dental provider believes a product purchased at a lower rate is not of the same quality as those purchased for private pay patients, the provider can refer the patient to another dentist who continues providing dentures or partials for IHCP patients.

To All Physicians:

- Chapter 8 of the *IHCP Provider Manual* states that the IHCP began reimbursing for postoperative epidural catheter management services using procedure code 01996 for dates of service on or after January 1, 1997.

  The IHCP does not pay for procedure code 01996 when it is billed for the same day the epidural is placed, but claims for this procedure code are billable on subsequent days when the epidural is being managed. This code is used for daily management of patients receiving continuous epidural, subdural, or subarachnoid analgesia, and is limited to one unit of service for each day of management. Procedure code 01996 is only reimbursable during active administration of the drug.

  Current Procedural Terminology (CPT) codes 99231, 99232, or 99233, for subsequent hospital care, are used for medically necessary, nonroutine postoperative visits, such as when an anesthesia provider sees the patient for potential problems experienced after epidural, subdural, or subarachnoid analgesia has been discontinued.

To All Acute Care Hospital Providers:

- This corrects information presented in Chapter 8 of the *IHCP Provider Manual* regarding treatment room visits. Treatment room visits are billed using revenue codes 45X, 51X, 52X, 70X, 72X, and 76X. Additionally, treatment room services are reimbursed at a flat rate that includes most drugs and supplies.

  The *IHCP Provider Manual,* published on April 30, 2002, incorrectly states, "Reimbursement is limited to a maximum of one unit per day, per revenue code, per member, per provider." The correct statement is: Reimbursement is limited to one unit per day, per patient, per provider. For more information about the outpatient prospective payment system and billing guidelines, refer to chapters 7 and 8 of the *IHCP Provider Manual* which is available on the IHCP Web site at www.indianamedicaid.com, or direct questions to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

- The Surveillance and Utilization Review (SUR) Department identified utilization concerns related to errors in assignment of patient discharge status codes by acute care facilities. Instances of incorrect discharge status code assignment have resulted in significant overpayment of claims from the IHCP. SUR is advising all providers to carefully review and ensure proper discharge status code assignments. To recoup overpayments, the SUR Department is conducting a review of these claims.

  Special payment policies apply to transfer cases paid using the diagnosis-related grouping (DRG) methodology. The receiving, or transferee, hospital is paid according to the DRG or level-of-care (LOC) methodology, whichever is applicable. Transferring hospitals are reimbursed a prorated DRG daily rate for each day, not to exceed the full DRG amount.

  To ensure proper reimbursement, the following discharge status codes must be placed in box 22 on the UB-92 claim form:

- 02 – discharge or transfer to another short-term hospital for inpatient care.
- 05 – discharge or transfer to another type of institution for inpatient care.

All transfers are subject to retrospective review. To obtain specific instructions for billing transfers, see Chapter 8 of the *IHCP Provider Manual* or refer questions about patient discharge status codes to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. If a provider identifies overpayments related to such errors, the provider should file an adjustment or contact the SUR Department to arrange for repayment of inappropriate reimbursement.

To All Providers:

- The Indianapolis workshop to be held November 15, 2002, at St. Vincent's Hospital is at capacity. **No walk-ins will be accepted**.

To All Pharmacy Providers:

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

- As a result of periodic and ongoing review of paid pharmacy claims, it was identified that some pharmacies were submitting *brand medically necessary* overrides on claims for generic drugs. This billing practice inappropriately suspended otherwise applicable maximum allowable charge (MAC) rates resulting in overpayments to providers. The overpayments will be recouped by the Office of Medicaid Policy and Planning (OMPP) and systems modifications made that will preclude future instances of this inappropriate billing practice.

  The mass adjustment will be December 27, 2002, for providers that received inappropriate reimbursement for *brand medically necessary* overrides on claims for generic drugs. This mass adjustment will appear on the December 31, 2002, remittance advice (RA). Refer questions about this mass adjustment to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To Pharmacy Provider and Nursing Facilities:

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

- In accordance with federal regulations, certain pharmacy services for Medicare members in skilled nursing facilities (SNF) are reimbursed under the Medicare nursing facility per diem. Per *42 CFR Part 409.25* Medicare pays for drugs and biologicals as post-hospital SNF care assuming it represents a cost to the facility and is furnished to an inpatient for use in the facility. Therefore, the IHCP should not be billed for these pharmacy services provided to dually eligible SNF residents during a Medicare post-hospitalization period. Drug products dispensed for these residents should be billed to the nursing facility only. During a recent review and audit of pharmacy claims, the OMPP determined some pharmacies have received payments for drug products dispensed to residents of nursing facilities that are eligible for both Medicare and Medicaid benefits when the resident was in a Medicare period of skilled care following hospitalization.

  A mass adjustment will be December 27, 2002, for providers that received inappropriate reimbursement for drug products in these situations and will appear on the December 31, 2002, RA. Refer questions about this mass adjustment to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

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