IMPORTANT INFORMATION

BR200302 JANUARY 14, 2003

To All Providers:

- The Office of Medicaid Policy and Planning (OMPP) received inquiries about the need for a business associate agreement between providers and Indiana Health Coverage Programs (IHCP). According to the Health and Human Services (HHS) Office for Civil Rights (OCR) guidance published, December 4, 2002, for the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, providers are not generally considered business associates of health plans. If the only relationship between the provider and the health plan is submission and payment of claims, the provider is not considered a business associate of the health plan.

  An accounting firm, which provides accounting services to a health care provider and must access protected health information, is considered a provider's business associate. Also, accreditation agencies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), are considered business associates of accredited entities. For additional information about the requirements for a business associate relationship, please refer to *45 CFR 160.103* or the OCR HIPAA Web site at http://www.hhs.gov/ocr/hipaa/whatsnew.html.
- *Medicaid Select*, the new managed care program for Indiana's aged, blind, and disabled populations, began enrollment of members in Marion County effective January 15, 2003. Refer to provider bulletin *BT200257* for program details. Continue to check for both IHCP eligibility **and** enrollment in one of the managed care programs using one of the IHCP eligibility verification systems. The automated voice-response (AVR), Web interChange eligibility inquiry, OMNI, and Provider Electronic Solutions systems provide the member's current primary medical provider (PMP) assignment. The member's program is identified as either Primary Care Case Management (PCCM) or Hoosier Healthwise PCCM without specific reference to the *Medicaid Select* program.

  Note: The PMP information in each of these systems is correct and all procedures described in IHCP provider bulletin BT200357 *apply on the member's enrollment date.*

  The AVR, Web interChange eligibility inquiry, OMNI, and Provider Electronic Solutions will be updated to reference *Medicaid Select* by June 2003. More information about updates to the eligibility verification systems will be sent in future bulletins and banner page messages.
- EDS identified claims paid as duplicates for *Edit 5008*. The recoupment of the duplicate Medicare Part A, B, and C claims will not be adjusted January 14, 2003, as previously stated. Recoupment will take place January 28, 2003. Direct questions and concerns to Customer Service at (317) 655-3240 in the Indianapolis area or 1-800-577-1278.

To All Pharmacy Providers:

Note: The information in this banner page article is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system

- Drug manufacturer rebates are an important part of cost containment for the Indiana Health Coverage Programs (IHCP). To prevent erroneous calculations for drug manufacturer rebates, it is important to understand how rebates are calculated. The rebate calculation is based on the **UNITS** dispensed, and not the usual and customary or billed amount. If a prescription is not entered correctly, the rebate amount could be based on twice or one-half of the correct amount. The following is an example:
  - The prescription reads: Risperdal: Take 1.25mg every day (QD).
  - The pharmacy dispenses: Risperdal 2.5mg and the patient is instructed to take one-half tablet QD.
  - The pharmacy bills for Risperdal 2.5mg, with a quantity of **30,** and reduces the amount billed to half of the usual and customary amount.

  In this example, the rebate calculation will be based on 30 units, instead of the correct amount of 15 units. The manufacturer would rebate twice the amount that it should. To receive appropriate rebates, the actual number of units dispensed must be reflected on the claim. Direct questions and concerns about this article to ACS at 1-866-879-0106.

To All Pharmacy Providers and Prescribing Practitioners:

Note: The information in this banner page article is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system

- Currently, a claim for a prescription that exceeds applicable quantity limitations displays explanation of benefits (EOB) *Edit 6806, Therapy Exceeds Limitation – PA Required*, and the claim is reimbursed up to the allowed

limit. For example, the IHCP allows 10 duragesic patches per month and a claim submitted for a quantity that exceeds 10. The claim will post *Edit 6806,* and allow reimbursement for patches up to the limit of 10. More information about this type of reimbursement was included in a banner page article in *BR200227*.

To achieve consistency with the standard of denying claims that exceed applicable quantity limitations and to address provider concerns, effective February 23, 2003, claims for quantities that exceed applicable limitations will deny, informing the pharmacist that limits have been exceeded, and no reimbursement will be applied.

- On February 23, 2003, ACS State Health Care will assume pharmacy claims processing for the IHCP from EDS. To assist pharmacy providers with this transition, ACS will begin testing point of sale (POS) claim submissions January 17, 2003, and continue through February 22, 2003. This article provides the information needed to submit POS pharmacy test claims to the ACS Prescription Drug Claims System (PDCS) beginning January 17, 2003.
- Testing is important when transitioning to a new claims processing system. Testing helps detect system errors before actual claims transmission begins. This POS pharmacy claims testing will allow ACS to determine if any problems or information issues exist. Additionally, testing allows providers to become comfortable with the different claim fields that are required with the PDCS, the new edits that may apply, and the new procedures that will be in place beginning February 23, 2003. Information about changes to the claim fields was provided in IHCP provider bulletin *BT200260*.

  In addition, ACS encourages providers to create their own testing scenarios. This will ensure providers obtain the best results from this testing process.

  To begin testing POS claims, the following information is required:
  - A valid IHCP provider number
  - Test BIN number – 610084
  - Test PCN – DRRXTEST

> *Note: Changes to the 3C transaction set for the POS claims submission process and other procedural changes were included in IHCP provider bulletin BT200260 and in the transition guide distributed at the provider training sessions.*

Questions about the testing should be directed in writing to Indiana.ProviderRelations@acs-inc.com or by calling the ACS POS help desk at 1-866 645-8344. When calling the ACS POS help desk providers must explain their questions to a representative and the questions will be forwarded to Provider Relations. Provider Relations will respond.

To All Pharmacy Providers and Nursing Facilities:

> *Note: The information in this banner page article is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.*

- 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 IHCP benefits when the resident was in a Medicare period of skilled care following hospitalization. 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. *42 CFR Part 409.25* indicates that Medicare pays for drugs and biologicals as post-hospital SNF care assuming it represents a cost to the facility and is furnished to a resident 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.

  A mass adjustment was completed the week of December 23, 2002, for providers that received inappropriate reimbursement for drug products when billing for members in these situations. This mass adjustment appeared on the December 31, 2002, remittance advice (RA). The mass adjustment was inappropriately processed and will run again during the week of January 6, 2003. Results of this mass adjustment will appear on the January 14, 2003 RA. An additional mass adjustment for claims with dates of service from August 1, 2002, through February 19, 2003, will be run during the week of February 17, 2003, and will appear on the February 25, 2003, RA. Refer questions about these mass adjustments to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.