IMPORTANT INFORMATION

BR200305 FEBRUARY 4, 2003

To All Providers:

- Medicare Remittance Notices (MRNs) are required and should be attached to claims submitted to process zero paid amounts from Medicare. The attachment verifies that the reason for non-payment is due to the amount being applied to the deductible. EDS will still process the claim as a *crossover*. If the attachment does not show that the amount entered in field 22 on the HCFA-1500 claim form or fields 39 through 41 on the UB-92 claim form was applied to the deductible, the claim will be returned. All other crossover claims are still processed according to Indiana Health Coverage Programs (IHCP) provider bulletin *BT200245*.

  Note: This requirement is related to Medicare deductible claims only.

- The printed version of IHCP provider bulletin *BT200303, 270/271 – Eligibility Request and Response Transaction Implementation*, dated January 31, 2003, contains an incorrect phone number. *Table 1.3 – OMNI Equipment Pricing Information,* on page 11 of the bulletin, lists the toll-free OMNI Help Desk number as 1-800-248-3548. The correct toll-free OMNI Help Desk number is 1-800-284-3548. A corrected version of this bulletin is available on the IHCP Web site at www.indianamedicaid.com.
- The printed version of IHCP provider bulletin *BT200303, 270/271 – Eligibility Request and Response Transaction Implementation*, dated January 31, 2003, contains an incorrect date. *Table 1.4 – Suggested OMNI Download Schedule* on page 12 of the bulletin lists the final download date for providers whose last names begin with **U** through **Z** as October 31, 2003. The actual final download date for these providers is October 15, 2003. The Web version of this bulletin contains the corrected information.
- The Office of Medicaid Policy and Planning (OMPP) received inquiries about the need for a business associate agreement between providers and 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.

To All Medicaid Select Providers:

- A primary medical provider (PMP) certification code is not required for any services submitted on Medicare crossover claims for members enrolled in the *Medicaid Select* managed care program for the aged, blind, and disabled. A PMP certification code is required on claims submitted for *Medicaid Select* members who do not have Medicare coverage for the following services:
  - Physician services not performed by the PMP or a *Medicaid Select* primary care case management (PCCM) enrolled practitioner within the PMPs group practice or clinic
  - Specialty and consultative physician services
  - Hospital inpatient admissions

- Outpatient services (except for therapy, laboratory, radiology, and pathology services)

Refer to IHCP provider bulletin *BT200262, PrimeStep PMP Certification Code Changes* for further information about the updated certification code requirements.

The remittance advice (RA) for administrative fee payments will show *Hoosier Healthwise* as the PCCM program type regardless of whether the payments are for *Medicaid Select*, Hoosier Healthwise, or both. The RA description will not change until later this year. The corresponding Managed Care Administrative Fee Listing categorizes *Medicaid Select* and Hoosier Healthwise payments.

The following new explanation of benefit (EOB) codes have been created for the *Medicaid Select* managed care program for the aged, blind and disabled.

- *1042* – Certification Code is Missing – Medicaid Select
- *1043* – Certification Code is Invalid – Medicaid Select
- *1044* – Recipient's PMP is Missing – Medicaid Select

To All Dental Providers:

- IHCP provider bulletin *BT200302*, dated January 15, 2003, announced a $600 annual cap on select dental services. The effective date of this dental cap has been changed from January 15, 2003, to **March 1, 2003**. All claims for dates of services rendered prior to March 1, 2003, will not count toward the $600 cap. Claims that have been processed and denied because the cap was already met will be reprocessed. Claims for dates of service prior to March 1, 2003, that have cutback due to this cap will be mass adjusted. Future banner page articles will announce information about reprocessing and mass adjusting these claims.