IMPORTANT INFORMATION

BR200307 FEBRUARY 18, 2003

To All Providers:

- Under the Health Insurance Portability and Accountability Act (HIPAA), only drugs and biologicals may be billed using a National Drug Code (NDC) on a pharmacy claim form. Consequently, as nutritional supplements are not considered drugs or biologicals, effective April 3, 2003, providers must bill the Indiana Health Coverage Programs (IHCP) for such services using Health Care Common Procedure Coding System (HCPCS) codes billed on the HCFA-1500 claim form. These claims must be submitted to EDS. As of April 3, 2003, nutritional supplements billed with NDCs on the pharmacy claim form will deny.

  Note: Effective for services beginning April 3, 2003, requests for prior authorization (PA) of nutritional supplements must be requested using the appropriate HCPCS codes. If a provider bills for a nutritional supplement after April 3, 2003, and the provider was previously granted PA using an NDC, the provider must contact the Health Care Excel PA Department at (317) 347-4511 or 1-800-457-4518 to request modification of the PA to reflect the appropriate HCPCS code.

- IHCP provider bulletin, *BT200308*, recently announced completed amendments related to medical and surgical supplies reimbursed by the IHCP. Information provided in this bulletin addressed the current covered incontinence supply codes to be used as of January 1, 2003. Providers that dispense incontinence supplies should remember that the annual maximum allowable reimbursement is $1,950 per member per rolling calendar year. The total reimbursement for any combination of supplies billed using A4335, A4360, A4554, S8401, S8403, S8404, and S8405 is limited to the $1,950 per member per rolling calendar year. Additionally, providers can only supply such services to an IHCP member in 30-day increments. Providers may reference IHCP provider bulletin *BT200130*, dated August 3, 2001, for additional information about the monthly maximum and annual allowance for incontinence supplies per member. Providers must work with families to ensure that the needs of the member are met within the $1,950 amount. Routine supplies are included in the per diem for members in LTC facilities and are not separately billable to IHCP.
- IHCP provider bulletin *BT200309*, dated February 17, 2003, informs providers about upcoming workshops for the HIPAA 270/271 transactions and the *Medicaid Select* program. These workshops are being offered in March, April, and May. This bulletin was placed on the IHCP Web site at http://www.indianamedicaid.com on February 6, 2003. The printed version is currently being mailed to providers. Providers may print the registration form from the Web site and fax completed registrations to register for workshops prior to receiving the printed version. The registration deadline for the first workshop is February 25, 2003. Please direct any questions about these workshops to EDS provider representatives at (317) 488-5195.
- 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 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.

To All Long Term Care and Durable Medical Equipment Providers:

- The IHCP recently identified that providers are inappropriately requesting customized wheelchairs for long-term care residents. To qualify for custom wheelchairs, long-term care residents must be strong candidates for rehabilitation and the request for PA should reflect clear medical necessity for the equipment. A physician must sign the PA request. A physical medicine and rehabilitation practitioner (physiatrist) will review all requests before PA is approved. A custom wheelchair should not be requested for long term care residents with 24-hour care for the sole purpose of the following: to provide safety; to allow self-propulsion; to function as a restraint; to prevent a potential medical condition; or to cure a medical condition, including, but not limited to, decubitus ulcers.

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.

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.*

- Banner page *BR200106* dated February 6, 2001, informed providers of a policy in effect since August 1994 that medical supplies, nonmedical supplies, and routine durable medical equipment (DME) items 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) cannot be billed to the IHCP. The cost for these services is included in the facility per diem rate. An analysis performed on these claims determined inappropriate payment. A mass adjustment was performed on December 3, 2002, for the providers that billed for medical supplies, nonmedical supplies, and routine DME items provided to members in long-term care facilities. This mass adjustment was inappropriately processed and will run again the week of February 10, 2003, with results appearing on the RAs dated February 18, 2003. Refer questions about this mass adjustment to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To All Nursing Facilities:

- This is to remind nursing facilities of the cost report filing requirements effective July 1, 2002. Pursuant to *405 IAC 1-14.6-4(a),* each provider shall submit an annual Medicaid financial report no later than the last day of the fifth calendar month after the close of the provider's reporting year. In addition to the Medicaid financial report, nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit both a written and electronic cost report (ECR) file copy of their Medicare cost report that covers their most recently completed historical reporting period. To avoid a 10 percent penalty pursuant to *405 IAC 1-14.6-4(e)*, the Medicaid financial report, and both the written and electronic Medicare cost reports, as required above, must be filed on a timely basis. If you have any questions contact Myers and Stauffer, OMPP's rate-setting contractor, at (317) 846-9521.

To All Pharmacies and Prescribing Practitioners:

- This notifies providers that effective February 17, 2003, state maximum allowable cost (SMAC) rates will be adjusted as indicated in the following table. The Indiana Administrative Code (IAC) *405 IAC 5-24-4*, requires that the Office of Medicaid Policy and Planning (OMPP) periodically review the state MAC rates and adjust the rates as necessary to reflect prevailing market conditions.

  A future provider bulletin, *BT200314*, dated February 18, 2003, will list the complete Indiana Health Coverage Programs State MAC rates and include additional rate schedule updates. Please contact Myers and Stauffer at 1-800-877-6927, or (317) 846-9521 in the Indianapolis local area, to discuss any questions or concerns.

Drug Group	Brand Name	Generic Name	SMAC Rate
31	Keflex 500mg	Cephalexin 500mg	$0.1680
165	Lioresal 10mg Tablet	Baclofen 10mg Tablet	$0.1657
173	Lioresal 20mg Tablet	Baclofen 20mg Tablet	$0.3256
182	Mycostatin 100000U/ml Susp	Nystatin 100000U/ml Susp	$0.0486
210	Septra Suspension	Sulfamethoxazole W/TMP Susp	$0.0556

IMPORTANT PHARMACY UPDATE

FEBRUARY 18, 2003

To: All Pharmacy Providers and Prescribing Practitioners

Subject: Revised Date for Processor Change

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

Overview

The change in the Indiana Health Coverage Programs (IHCP) pharmacy claims processor from EDS to ACS State Healthcare, previously scheduled for February 23, 2003, will now occur March 23, 2003. ACS and EDS are jointly committed to a transition that is essentially transparent to the provider community. The additional time afforded by extending the change in processor date will better allow providers to incorporate into their businesses the transition-related information they obtain through bulletins, banner page messages, and the statewide training sessions. The additional time will also provide ACS and EDS enhanced capability to test and re-test the new system. The purpose of this document is to inform providers about how the extension date of the pharmacy claim processor change affects the pharmacy claim processing requirements that were communicated in IHCP provider bulletin *BT200260*.

Provider questions about the changes or the extension date should be directed in an e-mail that includes a detailed description of the questions to: Indiana.ProviderRelations@acs-inc.com or by telephone to the ACS Point of Sale (POS) Help Desk at 1-866-645-8344.

This document addresses updates to the changes in pharmacy claim processing that were communicated in IHCP provider bulletin *BT200260* for the following areas:

- Instructions for claims submission
- Help desk numbers
- Other changes

Instructions for Claims Submission

Paper Claims Using the Indiana Family and Social Services Administration Drug Claim Form

Through March 13, 2003, providers must continue to mail pharmacy claims on the Indiana Family and Social Services Administration (IFSSA) Drug Claim Form to EDS at the following address:

EDS Pharmacy Claims
P.O. BOX 7268
Indianapolis, IN, 46207-7268

After March 13, 2003, providers must mail pharmacy claims on the IFSSA Drug Claim Form to ACS at the following address:

Indiana Pharmacy Claims
C/O ACS
P.O. Box 502327
Atlanta, GA 31150

Provider Electronic Solutions

Provider Electronic Solutions can be used to send pharmacy batch and POS claims through March 22, 2003. After March 22, 2003, Provider Electronic Solutions can still be used to verify eligibility, but cannot be used to submit pharmacy claims.

National Electronic Claims Submission

National Electronic Claims Submission (NECS) can be used to send pharmacy batch and POS claims through March 22, 2003. After March 22, 2003, NECS can still be used to verify eligibility, but cannot be used to submit pharmacy claims.

Point of Sale

EDS will continue to accept POS claims through midnight March 22, 2003. Effective at noon March 23, 2003, POS claims must be submitted to ACS. After midnight March 23, 2003, the pharmacy claim processing system will be down for no more than twelve hours to transfer files necessary for the pharmacy claim processor change. If a fill of an emergency prescription is required between midnight March 22, 2003, and noon March 23, 2003, providers must follow the current paper claim emergency dispensing procedures. Nonemergency prescriptions filled during the downtime will be subject to normal edits.

For a full description of the POS changes required including the revised pharmacy claim format (now effective March 22, 2003), please see IHCP provider bulletin *BT200260*.

Batch Claims

EDS will continue to accept electronic pharmacy batch claims through 5 p.m. March 22, 2003. Providers should continue to use their EDS ID for batch claims submission when submitting claims to EDS. Changes to the current NCPDP 1.0 batch format are required beginning March 23, 2003, and are referenced in IHCP provider bulletin *BT200260*.

> *Note: Pharmacy claims submitted using* Provider Electronic Solutions *and NECS will not be processed after 5 p.m. March 22, 2003.*

For a full description of the required batch changes, including the revised payor sheet (now effective March 23, 2003), please refer to IHCP provider bulletin *BT200260.*

Helpdesk Numbers

Customer Service Helpdesk

Through March 22, 2003, providers should continue to contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 for claim related questions.

Other Changes

Third Party Liability Cost Avoidance Procedures

When members are identified as having pharmacy insurance coverage, providers must bill the pharmacy insurance carrier prior to submitting the claim to the IHCP and the system will continue to return an informational edit. Beginning March 23, 2003, the National Council for Prescription Drug Program (NCPDP) reject reason of 41 – *Submit Bill to Other Processor or Primary Payor,* will return a denial edit.

For a full description of third party liability (TPL) pharmacy claim processing procedures, please refer to IHCP provider bulletins *BT200221* and *BT200260.*