IMPORTANT INFORMATION

BR200311 MARCH 18, 2003

To All Providers:

- The following table contains changes to the 2003 Healthcare Common Procedure Coding System (HCPCS) published in the Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200313*, dated February 15, 2003.

Code	Description	Coverage
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	Non-reimbursable for all programs, Non-reimbursable for Package C Use CPT code 88174
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	Non-reimbursable for all programs, Non-reimbursable for Package C Use CPT code 88175
G0179	Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period	Not covered for all programs, Not covered for Package C
G0290	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	This code was incorrectly published as covered in BT200313. This code is not covered for all programs, not covered for Package C.
G0291	Transcatheter placement of a drug eluting intracoronary stent (s), percutaneous, with or without other therapeutic intervention, any method; single vessel	This code was incorrectly published as covered in BT200313. This code is not covered for all programs, not covered for Package C.

- In IHCP provider bulletin *BT200313*, published February 15, 2003, HCPCS code *A4538 – Diaper service, reusable diaper, each diaper*, was incorrectly identified as covered for all programs. Code A4538 is not covered for all programs, and is not covered for Package C benefits.
- The Health Care Excel (HCE) Medical Policy Department reviewed claims for services provided to Package B members during the postpartum period submitted for state fiscal years 2000 to 2002. Some claims were inappropriately paid for such diagnoses as open wound of scalp, nasal bone fracture, conjunctivitis, sprain of ankle, ingrown nail, sinusitis, bronchitis, myopia, astigmatism, and fracture of humerus. Chapter 8, Section 3 of the *IHCP Provider Manual,* states that when the pregnancy ends the Package B member is only eligible for transportation, family planning, and postpartum services. Urgent care services that are unrelated to complications of the puerperium are not reimbursed. Claims for services rendered to Package B eligible members during the 60-day postpartum period must be related to complications of or be a result of the pregnancy. This postpartum eligibility begins on the last day of pregnancy and extends though the end of the month in which the last day of the 60-day period occurs. The primary diagnosis code for postpartum services must be pregnancy-related or the claim will be denied. The pregnancy-related code must be indicated in form location 24E of the HCFA-1500 claim form.

  Note: This includes V codes and 600 series diagnosis codes that relate to pregnancy.

  If the specific reason for the visit or care is not adequately addressed by the pregnancy diagnosis code, the visit or care diagnosis must also be included as a secondary or tertiary diagnosis on the claim form. The pregnancy indicator P must be entered in form location 24H of the HCFA-1500 claim form.

To All Case Managers:

- Claims billed with code Z5141 that denied with edit 1041 after March 3, 2003, will be reprocessed the week of March 17, 2003, and will display on remittance advice dated March 24, 2003.

To All Dental Providers:

- The IHCP will issue a bulletin to correct information about coding dental services as published in HCPCS provider bulletin, *BT200313*, dated February 15, 2003. This bulletin will be mailed to dental providers and will be available on the IHCP Web site at www.indianamedicaid.com. This bulletin will provide the correct codes to use as of April 1, 2003.

To All Dental Providers of Mobile Dental Services:

- Effective July 1, 2002, *828 IAC4-1-1* required providers of mobile dental services be licensed as a mobile dental facility. Providers of mobile dental services should contact Health Professions Bureau at (317) 234-2010 for an application, and forward a copy of the mobile dental license to EDS Provider Enrollment by March 15, 2003. The mailing address is:

  EDS Provider Enrollment
  P.O. Box 7263
  Indianapolis, Indiana 46207-7263

To All Nursing Facilities:

- The Office of Medicaid Policy and Planning (OMPP) will hold free training about processing the *Form 450B* for residents in nursing facilities. The training will cover correct completion of the *Form 450B* as well as OMPP processing, and PAS/PASRR processing. Training sessions are being offered at two times on April 21, 2003. Sessions will be held from 8:30 a.m.-11:30 a.m. and from 1 p.m.-4 p.m. This training will be held in the Indiana Government Center South Auditorium located at 402 W. Washington Street in Indianapolis. Reservations are not required. Public parking is allowed only in Garage 1 located on Washington Street. Attendees are encouraged to plan for alternate parking because this garage may be full. The OMPP encourages nursing directors, admission coordinators, social service staff, and bookkeepers to attend. Training session attendees should bring copies of bulletins *E98-35* dated November 2, 1998, *E98-40* dated November 16, 1998, *BT199939* dated December 1, 1999, BT200002 dated April 5, 2000, and banner pages dated February 3, 1998, and January 28, 2003. Copies of these publications are available on the IHCP Web site at www.indianamedicaid.com**.** Call (317) 233-1958 for answers to questions about these training sessions only.
- A review of monthly long term care (LTC) claims for nursing facilities, community residential facilities for the developmentally disabled, and intermediate care facilities for the mentally retarded have reflected that a number of LTC providers are inappropriately billing charges for leave days to the IHCP. All leave days must be billed using a revenue code in the 180-185 series. Additionally, leave days are to be submitted at one-half of the per diem rate. EDS is currently contacting providers who have inappropriately billed leave days to assist with rectifying previously submitted claims. All providers, however, are reminded, if it is determined that leave day claims were submitted with a revenue code other than the 180-185 series, the claims will be required to be adjusted. All adjustment requests must be forwarded on the appropriate adjustment claim form and sent to:

  EDS Adjustments
  P.O. Box 7265
  Indianapolis, Indiana 46207-7265

  All procedures and mailing information are located in Chapter 11, Paid Claim Adjustment Procedures, of the *IHCP Provider Manual*. Failure to adjust erroneously submitted claims in a timely manner may result in a claim audit.
- This article provides information about the procedures for providers requesting an exception to the 65 percent minimum occupancy requirements. Providers requesting an exception to this requirement should submit a written request and any supporting documentation to Myers and Stauffer, LC. Myers and Stauffer, LC, will notify the provider of the determination of the exception request by means of the rate notification letter that is applicable to the effective date of the request. Providers should continue to send exception requests to Myers and Stauffer, LC, at 8555 North River Road, Suite 360, Indianapolis, IN 46240.

To All Pharmacy Providers and Prescribing Practitioners:

- After an additional review of Medicare Part A claims, the OMPP determined that the mass adjustment initiated on December 27, 2002, to recover payments for drug products dispensed for residents of nursing facilities when the resident was in a Medicare period of skilled care following hospitalization, included claims for drugs that were dispensed on the date of discharge. The OMPP has further determined that these payments were appropriate at the time of reimbursement. Accordingly, a mass adjustment will be initiated no later than March 17, 2003, to reimburse those funds for drug claims in which the dispense date was the same as the date of discharge from the Medicare period of skilled care.

  Questions about this mass adjustment may be addressed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800- 577-1278 outside of Indianapolis.
- This article provides information for pharmacy providers and prescribing practitioners who submit batch pharmacy claims. Batch pharmacy claims submitted electronically after 5 p.m., Friday March 21, 2003, must be submitted to ACS State Healthcare. Batch pharmacy claims received by EDS after 5 p.m., Friday March 21, 2003, will be rejected, and an error code *010 – Pharmacy claim type not accepted*, will be displayed on the Biller Summary Report. This includes providers using Provider Electronic Solutions software, NECS software and any other vendor software or clearinghouse used to submit batch pharmacy claims. This change does not affect Managed Care Organizations sending pharmacy batch shadow claims. Shadow pharmacy claims will continue to be received and processed in batch form.

  For information about sending batch pharmacy claims to ACS please contact the ACS helpdesk by e-mail at Indiana.ProviderRelations@acs-inc.com or by calling 1-866-645-8344.