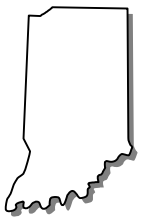

IMPORTANT INFORMATION

BR200314 APRIL 8, 2003

To All Providers:

- Providers must always verify member eligibility on the date services are provided. The eligibility system indicates a 590 member, verify the facility where the member resides or resided. If the eligibility system indicates a 590 member, and the member no longer resides in a facility, consider the member fee-for-service. Notify the EDS 590 provider representative at (317) 488-5182, and provide the following information:
  - Provider name and telephone number
  - 590 members' name and member identification (RID) number
  - Facility where the member resided

  All claims for 590 members who reside in a facility that are less than $150 should be billed to the facility where the member resides. All claims of more than $500 that are billed for a 590 members who resides in a facility must have prior authorization (PA) from Health Care Excel (HCE) and then be submitted to EDS for processing. Send all 590 claims to the following address.

  EDS 590 Program Claims
  P. O. Box 7270
  Indianapolis, IN 46207-7270
- Pursuant to the *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule* that goes into effect April 14, 2003, the Indiana Health Coverage Programs (IHCP) started mailing the *IHCP Notice of Privacy Practices* to all active IHCP members March 19, 2003. Active members will receive a copy of the notice prior to the required compliance date and on an ongoing basis, new IHCP members will receive a copy of the notice shortly after program enrollment.
  A copy of the IHCP *Notice of Privacy Practices* is available for reference at http://www.indianamedicaid.com/ihcp/Bulletins/BT200316.pdf. The IHCP will not mail or fax copies of the notice to providers; however, a copy can be printed from the Web site.
- During the first week of March 2003, EDS activated EOB *1012 – Procedure billed not payable for this provider specialty*. The intent was to apply billing and coverage policy with respect to a specific program. However, this system update inadvertently impacted CMS-1500 claims for provider specialties such as mental health and transportation. Claims affected by this update were posted on provider remittance advice (RA) statements issued on March 11, 2003, and March 18, 2003. EDS will systematically reprocess and mass adjust affected claims within the next 30 days of the date of this article.
- Several recent banner messages clarified that under HIPAA, only drugs and biologicals may be billed using a National Drug Code (NDC) on a pharmacy claim form. These banners also stated that nutritional supplements are not considered drugs or biologicals and are not billable on a pharmacy claim form, effective April 3, 2003. Enteral formulas that do not contain a drug must be billed on a CMS-1500 using the appropriate Healthcare Common Procedure Coding System (HCPCS) B code (B4150 through B4156). Compounded parenteral nutrition solutions, containing a legend drug, should be billed only on a compound prescription drug claim form and should not be billed under HCPCS codes B4164 through B5200.
- A review of claims processing history for procedure code *90999-Unlisted Dialysis Procedure in Hospital or Outpatient* determined that Medicare secondary claims for dialysis were not reimbursing according to Indiana Health Coverage Programs (IHCP) reimbursement standards. Specifically, Medicare requires dialysis claims to be submitted with a code of 90999. For Medicare secondary claims, this code was reimbursed by the IHCP at a rate of $435.60. If providers bill the IHCP primary for dialysis, they should use code *90935-Hemodialysis Procedure with Single Physician Evaluation*. This code reimburses at a rate of $72.64. Effective March 13, 2003, procedure code 90999 has been updated to mirror the rate for 90935, $72.64. On May 19, 2003, EDS will systematically adjust all claims reimbursed at the greater rate for 90999 that were submitted over the past 36 months. This adjustment may result in an accounts receivable (A/R) on the provider's financial statement.

To All Dental Providers:

- Some dental providers received duplicate claim payments between January 2, 1999, and January 2002. Providers effected by this overpayment received a letter in October 2002, that announced the overpayment and asked providers to refund the overpayment amount. Adjustments will begin the week of April 21, 2003 and will show up on the April 29, 2003 RA on all effected claims that have not been refunded to the IHCP.
- Subsequent to the release of bulletin *BT200321, Correct Codes for Billing IHCP Dental Services*, an error was discovered regarding codes D2932 and D2933. The IHCP does not cover D2932, *Prefabricated resin crown.* The IHCP only pays for stainless steel crowns. D2933, *Prefabricated stainless steel crown with resin window*, is only covered for members younger than 21 years old and is not included in the dental cap.
  If a provider must bill a primary tooth code for a member who is 21 years old or older, then the procedure will count toward the member's $600 annual limit.

To All Providers in Parke, Putnam, Hendricks, Hamilton, Tipton, Howard, Cass, Carroll, White, Tippecanoe, Warren, Clinton, Benton, Fountain, Montgomery, Boone, and Vermillion Counties

- On Friday May 16, 2003, Chris Kern, EDS provider relations consultant, will present an IHCP 101 workshop for all **NEW** providers and billing agents for the aforementioned counties. The IHCP 101 workshop will be held on the second floor of the Howard Community Hospital billing office at 3611 S. Reed Rd. Handouts will be provided to all attendees. Seating for the workshop will be reserved based on the order in which requests are received. There will be a morning and an afternoon IHCP 101 session (two sessions covering the same material). The first session will be from 8:30 a.m. to 11:30 a.m. The second session will be from 1 p.m. to 4 p.m. Seating is limited to 40 spaces per session and

two individuals per provider number. To sign up for a session, please contact Chris Kern at (317) 488-5326 and indicate the morning or afternoon session, contact name, and telephone number. An EDS Provider Relations representative will call to confirm the attendees and session. No confirmations letters will be mailed. You must confirm your registration with the Provider Relations representative who returns your call. The registration deadline is April 25, 2003.

Note: If the morning session is full, all other attendees will be added to the afternoon session.

To All Pharmacy Providers and Prescribing Practitioners:

- Please note the following correction to IHCP provider bulletin *BT200319* about PDL limits on Tramadol. The limit should read: *400mg of Tramadol a day and 300mg a day for persons over 70 years of age*. The online text for *BT200319* is correct.
- During the February 21, 2003, Drug Utilization Review (DUR) Board meeting, the DUR Board approved the following changes effective as of May 14, 2003:
  - Remove the early refill edits for all Warfarin products
  - Add over the counter (OTC) Loratadine products to the OTC Drug Formulary

To All IHCP-Enrolled Hospice Providers:

- The OMPP reused four IHCP hospice forms. The forms are now available at the State Form Distribution Center. Hospice providers should refer to Section 3 of the *IHCP Hospice Manual* (revision date August 2002) for procedures on how to obtain these new forms.
  The following forms have been revised:
  - Medicaid Hospice Physician Certification Form, *State Form 48736 (R2/12-02)/OMPP 0006*
  - Medicaid Hospice Plan of Care Form, *State Form 48731 (R/12-02)/OMPP0011*
  - Hospice Provider Change Request Between Indiana Hospice Providers, *State Form 48733 (R/12-02)/OMPP 0009*
  - Medicaid Hospice Discharge Form, *State Form 48734 (R/12-02)/OMPP 0008*

  These forms are available as *fill-in versions,* and are now online in the FSSA.PDF Catalogs. Providers who have Adobe Acrobat® 5.0 can access these forms online, insert the information required in each field, print the document and then have staff provide the appropriate signatures. ***The fill-in versions do not have the capacity to be saved for future use.*** The forms may be accessed at the following Web site: http://www.state.in.us/icpr/webfile/formsdiv/fssa.html.
  Further information about these revised IHCP hospice forms and the upcoming one-page hospice notification sheet for dually-eligible Medicare/IHCP hospice members residing in nursing facilities will be outlined in a bulletin detailing hospice rule changes. The bulletin is scheduled for release in May or June 2003.

To All Medicaid Primary Care Case Management Providers:

- The primary medical provider (PMP) certification code changes that were outlined in IHCP provider bulletin *BT200262* became effective beginning with **dates of service** January 15, 2003. A change was made to include provider specialty 094 for Certified Registered Nurse Anesthetists (CRNAs) in the list of rendering provider specialties indicated in the above mentioned bulletin that do not require the PMP's certification code when billing services. Claims that were billed for services rendered by a CRNA with dates of service on or after January 15, 2003, that denied for certification code edits 342, 343, 1042, or 1043 and member's PMP is missing edits 1011 and 1044 can be resubmitted for claim payment.

To All IHCP Hospital, Ambulatory Surgical Center, Physician, and Durable Medical Equipment Providers:

- Cyberonics, Inc., contacted the OMPP to introduce the new Vagus Nerve Stimulator (VNS) Therapy™ Model 102 Generator and Model 302 Bipolar Lead. These new products replace the VNS Therapy™ Model 101 Generator and Model 300 Lead. According to the manufacturer specifications, the new Model 102 Generator is not compatible with the older Model 300 Lead and the new Model 302 Lead is not compatible with the older Model 101 Generator. The new Model 102 Generator must only be used with the new Model 302 Lead. The VNS Generator (Model 101) is currently reimbursed by IHCP using HCPCS code E0756, *Implantable neurostimulator or pulse generator*, at a maximum fee of $9,753.00. The VNS Lead (Model 300) is currently reimbursed by the IHCP using HCPCS code E0752, *Implantable neurostimulator electrode, each*, at a maximum fee rate of $2,030.00. The maximum fee reimbursement for these codes has been increased to cover the additional cost of the new models. The Model 101 Generator and Model 300 Lead are available only for reimplantation, for cases in which replacement of the same model is necessary. Providers billing for older models of the VNS Therapy™ Generator or Bipolar Lead should bill the codes listed; however, the usual and customary charge for the specific model should be submitted for reimbursement. The maximum fee for the VNS Therapy™ Model 101 Generator, and Model 300 Lead **have not been increased**. The pricing for the Model 102 Generator and Model 302 Lead have been activated as of April 1, 2003, and is retroactive for claims with dates of service effective January 1, 2003.

To All Inpatient Acute Care Providers:

- IHCP provider bulletin, *BT200245*, announced a new inpatient crossover reimbursement method set forth in *IFSSA Emergency Rule LSA#02-121*. Inpatient Medicare Part A crossover claims that cannot be grouped to a DRG will continue to allow the full Medicare coinsurance and deductible. **All** inpatient Medicare Part A claims continued to reimburse the full Medicare coinsurance and deductible until the necessary system modifications were implemented during the last week of January 2003. Those changes have been verified and inpatient Medicare Part A crossover claims are processing correctly. All inpatient Medicare Part A crossovers received between August 14, 2002, and January 31, 2003, that should have priced with the new crossover reimbursement method, will be systematically mass adjusted. The claims affected by the systematic mass adjustment will appear on RAs dated on or after May 27, 2003.

I M P O R T A N T P H A R M A C Y U P D A T E

A P R I L 8 , 2 0 0 3

To: All Pharmacy Providers and Prescribing Practitioners

Subject: Third Party Liability Pharmacy Cost Avoidance

On March 23, 2003, the Indiana Health Coverage Program's (IHCP) Pharmacy Benefits Manager (PBM), ACS State Healthcare began processing IHCP pharmacy claims. While several issues were identified and resolved during the first two weeks of operations, providers have expressed concern surrounding third party liability (TPL) cost avoidance.

Effective July 1, 2002, the IHCP implemented pharmacy cost avoidance. This means that providers are required to determine, prior to submitting a claim to Medicaid, whether the member has TPL pharmacy coverage. When a member has coverage, providers are required to follow the claims submission procedures outlined in IHCP provider bulletins *BT200317* and *BT200221*. While the policy for TPL cost avoidance became operational on July 1, 2002, TPL edits were not operational until the transition to the PBM claims processing system on March 23, 2003.

The Office of Medicaid Policy and Planning (OMPP) offers the following clarifications in response to TPL-related questions raised by the provider community:

- In instances where a member may have TPL coverage, but the TPL carrier does not accept point-of-sale (POS) claims, providers are still required to bill the TPL carrier. However providers may choose one of the following methods:

  1. Providers may dispense, bill the TPL carrier, and wait for a response. Upon receiving a response from the TPL carrier, the provider may then bill IHCP via POS.

  2. Provider may dispense and bill the IHCP through POS utilizing an override code of 4 – *other coverage exists, no payment collected.* However, if providers choose to bill in this manner, the IHCP requires that the provide bill the TPL carrier and submit a paid claims adjustment when payment is received from the TPL carrier.

- When a member indicates to a provider that they no longer have other insurance coverage, the provider may file a claim using the override code 4 in the **Other Coverage** field. However, as required in all instances for which an override code is utilized, the provide must maintain documentation which justifies the use of the override code. Additionally, to avoid continued use of an override for the same member, providers should inform the member they must contact their caseworker to update the insurance file or the provider may contract the TPL unit at EDS at (317) 488-4527 or 1-800-457-4510. The TPL Unit will update the file accordingly.

- Discount cards are not considered other coverage for purposes of TPL cost avoidance. If a member has a discount card, the provider must follow the same procedures outlined above for members who have lapsed insurance.

During the first day of operations, call volume to the ACS Call Center was significantly higher which resulted in a longer than average call waiting time. Throughout the last two weeks, ACS has worked to make the needed system modifications on issues identified through provider input to the call center. As a result of these system modifications, the call volume has decreased dramatically and therefore the call waiting time has now returned to normal. The OMPP would like to thank providers for their patience and diligence throughout this transition period. Please note that problems that have been identified are being addressed and fixed in most cases within 24 to 48 hours. We appreciate the feedback received from the provider community.

We are recommending that providers who believe they received invalid claims denials due to system-related issues may choose to resubmit claims that may have previously denied. If you have any questions concerning these claims, please contact the ACS Call Center at 1-866-645-8344.

Scheduled Down Time

Please be advised that ACS is planning an extended downtime of the POS claims processing system for the morning of Sunday April 13, 2003. While the system is regularly not available for POS claim submission from midnight to 2:00 a.m. each Sunday, on April 13, 2003, the outage will be from midnight to 6:00 a.m. If you have any question please contact the ACS Call Center at 1-866-645-8344.