IMPORTANT INFORMATION

BR200315 APRIL 15, 2003

To All Providers:

- Due to a processing error, Medicare Part B claims without an invoice attached that were billed for dates of service prior to July 1, 2002, and denied for manual pricing will be reprocessed and paid. Payments for these claims should appear on the remittance advice (RA) dated April 22, 2003.
- Providers must always verify Indiana Health Coverage Programs (IHCP) member eligibility on the date they provide services. If the eligibility system indicates a member is a 590 Program member, the provider should verify the facility where the member resides or resided. If the member is identified as a 590 Program member and the member no longer resides in a facility, the provider should consider the member fee-for-service and notify the EDS 590 provider representative at (317) 488-5182. The provider should give the provider representative the following information:
  - The provider's name and telephone number
  - The 590 Program member's name and member identification (RID) number
  - The name of the facility in which the member resided

  If a member resides in a facility, all claims less than $150 must be billed to the facility where the member resides. All claims more than $500 must be prior authorized by Health Care Excel (HCE), and then be submitted to EDS for processing. Send all 590 claims of more than $150 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 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.

To All Pharmacy Providers and Prescribing Practitioners:

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

- At the March 28, 2003, DUR Board meeting, the Over the Counter (OTC) Drug Formulary was expanded to include oral electrolyte replenishing solutions. In the past, these products were understood to be, and considered by the IHCP as supply items, as opposed to drugs. Given that it was recently determined that the products are OTC drugs, they have been added to the OTC Drug Formulary. Please note that only drug products from a rebating manufacturer will be reimbursed. Currently, the participating manufacturers of electrolyte replenishing solutions are: Abbott Labs, Bergen Brunswig; Brite Life; Goldline Drug; Ivax/Goldline; Leader; Major Pharm; MJ Nutritional; Pan American; Reese Chemical; Ross Labs; Rugby; and Select Brand. The state maximum allowable charge (MAC) rate for oral electrolyte replenishing solutions is $0.00472 per ml. The effective date for the addition to the OTC Drug Formulary is May 5, 2003. The products remain reimbursable under the program in the interim.
- Effective April 8, 2003, the maximum allowable fees for the following medical supply products have been changed as indicated in the following table:

Code	Item Name	New Price
A4360	Colostomy Set	$0.95
A4253	Blood Glucose Test	$35.00
A5061	Pouch, Drainable	$2.72
A5055	Stoma Cap	$1.32
A4406	Ostomy Skin Barrier	$7.35
A5063	Ostomy Pouch Drainable	$2.23
A4362	Skin Barrier; Solid, 4 X	$2.71
A4373	Skin Barrier With Flange	$5.09
A5052	Pouch, Closed	$1.22
A5073	Pouch, Urinary	$3.14
A5123	Skin Barrier; With Flange	$3.51
A4250	Urine Test Strips	$14.62

  Please direct any questions to Jared Duzan at Myers and Stauffer at (800) 877-6927, (317) 846-9521, or jduzan@mslc.com.
- 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.

To All Waiver Providers:

- The purpose of this Home and Community Services (HBCS) Waiver update is to clarify the HCBS Waivers standards and rule promulgation. The *Final Rule Title 460 IAC 6* Division of Disability, Aging and Rehabilitative Services is in effect for the Autism, Developmental Disability, and Support Services HCBS Waivers effective January 1, 2003. In addition, the documentation standards are in effect, and were published in provider bulletin *BT200305*. For the Aged and Disabled, Traumatic Brain Injury, Medically Fragile Children, and Assisted Living Waivers, the Bureau of Aging and In Home Services is in the process of rule promulgation. This rule will be separate from the *Title 460 Rule* and will be forthcoming.

  All HCBS Waivers Providers are subject to and should be in compliance with the following IHCP IAC Guidelines:
  - *405 IAC 1-1-4* – Denial of claim payment

- *405 IAC 1-1-5* – Overpayments made to providers; recovery
- *405 IAC 1-1-6* – Sanctions against providers
- *405 IAC 1-5-1* – Medical records; contents and retention
- *405 IAC 5-1* – General Provisions
- *405 IAC 5-2* – Definitions
- *405 IAC 5-4* – Provider Enrollment
- *IC 12-15-13-3* – Appeal Procedures
- *Indiana Health Coverage Programs Manual*
- All IHCP Home and Community Based Waiver bulletins
- All DDARS Waiver bulletins

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 on all effected claims that have not been refunded to the IHCP will begin the week of April 21, 2003 and will show up on the April 29, 2003, RA.
- 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 Nursing Facilities:

- The OMPP training sessions about processing the *Form 450B* for residents in nursing facilities has been moved from the auditorium to **conference rooms A-B-C** across the hall. The conference rooms are located at 402 W. Washington Street in Indianapolis. 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.
  Training sessions are being offered at two times on April 21, 2003. Sessions will be held from 8:30 a.m. to 11:30 a.m. and from 1 p.m. to 4 p.m. 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, and *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**.**

Note: The date and times of the sessions were not changed, just the location. Call (317) 233-1958 for answers to questions about these training sessions only.

To All Medicaid Primary Care Case Management Providers:

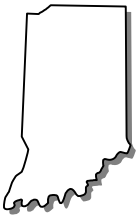
- The primary medical provider (PMP) certification code changes that were outlined in IHCP provider bulletin *BT200262* became effective beginning with **dates of service** January 15, 2003. A change was made to include provider specialty 094 for Certified Registered Nurse Anesthetists (CRNAs) in the 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.