IMPORTANT INFORMATION

BR200330 JULY 29, 2003

To All Providers:

- When billing outpatient surgeries, any ancillary services provided are included in the Ambulatory Surgery Center (ASC) payment for the surgery. Any outpatient claims that have ancillary charges billed separately on a different claim form from the surgery, will be denied with explanation of benefits (EOB) code *5012 – Ancillary charges are not reimbursable on an outpatient claim, when a surgical procedure is paid by Ambulatory Surgery Center (ASC) pricing*.
- The Health Insurance Portability and Accountability Act (HIPAA) *Transaction and Code Set* rule is being implemented on October 16, 2003. To ensure compliance of your electronic transactions, the Indiana Health Coverage Programs (IHCP) has begun to schedule testing of transactions with software vendors and trading partners that include, but are not limited to clearinghouses, value added networks (VAN), and so forth. For your convenience, a list of all trading partners and their testing status is available on the IHCP Web site at www.indianamedicaid.com. It is strongly advised that you check this list for the testing status of your trading partner or software vendor. If they are not listed, it is advised that you contact them to inquire if they will be tested and HIPAA compliant with the IHCP prior to the October 16, 2003, implementation date. In addition, you should work with them to identify new data elements that are required for processing. The Web interChange will have claims submission capability, claim inquiry, and eligibility available for use prior to or by October 16, 2003.
- IHCP provider bulletin *BT200335*, published June 3, 2003, listed incorrect IHCP capped rental pricing for rental equipment under Healthcare Common Procedure Coding System (HCPCS) codes K0010, K0011, and K0012. The correct IHCP capped rental pricing for each code is found in the following table.

HCPCS Codes with RR Modifiers	IHCP Capped Rental Pricing
K0010	$282.59
K0011	$351.35
K0012	$215.54

- The April 2003 version of the IHCP Provider Manual contains revised information for the Restricted Card Program's procedures. Refer to Chapter 2, Section 6: Restricted Utilization, and Chapter 13, Section 4: Member Utilization Review Process. Providers can direct questions regarding the Restricted Card Program to Health Care Excel (HCE). In the Indianapolis local area at (317) 347-4527, or toll free at 1 800-457-4515.

To All Pharmacy Providers:

- ACS has identified a limited number of instances in which, related to implementation of the PDCS pharmacy claims processing system, dispensing fees that should have been reimbursed were not. The systems problem that caused these isolated instances has been identified and corrected. Beginning August 4, 2003, the claims for which a dispensing fee

was erroneously omitted will be mass adjusted in order to pay the missing fees. ACS regrets any inconvenience this systems problem may have caused, and appreciates providers notifying of the situation.

Long-standing Medicaid law at *405 IAC 5-24-6(b)* provides for a maximum of one dispensing fee per legend drug order per recipient per month, for those members residing in long term care facilities. PDCS was initially programmed such that a month was operationally defined as 29 days. OMPP, after consultation with representatives of the long term care pharmacy industry, has since determined that a more practical and equitable definition of "month" would have it as 28 days. Therefore, on July 18, 2003, the PDCS was modified to use 28 days as constituting a month, for purposes of *405 IAC 5-24-6(b)*. Please note that ACS will mass adjust all subject drug claims for dates of service from March 23, 2003 (implementation of PDC) to July 18, to reflect the revised policy.

To All Hospitals, Inpatient Facilities, and Acute Care Facilities:

- When a spenddown member has an inpatient stay that spans multiple months and the date of the discharge is the first day of a month, the claims will deny for EOB code *3005 The claims covers multiple months and spenddown has not been met for all months billed on the claim*. Effective immediately, these claims should be submitted to the Written Correspondence Unit for processing with an attached cover letter referencing this banner page article. If a claim is past the one-year filing limit, the claim must be submitted with the required documentation. For further information about claim filing documentation refer to *Chapter 10, Section 5,* of the *IHCP Provider Manual.*

To All Hospice and Managed Care Providers:

- The purpose of this banner page article is to remind hospice providers that it is their responsibility to verify IHCP eligibility upon taking any admission to the hospice program, and regularly, at least once a month. When the IHCP eligibility verification system specifies that a member is enrolled in managed care, the hospice provider must follow the procedures outlined in the *IHCP Hospice Programs Manual, August 2002,* and IHCP provider bulletin*, BT199905,* published January 26, 1999, and fax the hospice election form to the Health Care Excel (HCE) Prior Authorization Unit at (317) 347-4537, so that HCE may coordinate with Americhoice, the IHCP's managed care enrollment broker contractor, to disenroll the member from managed care on that same day. The hospice provider may then start billing the IHCP for hospice services the day following the member's disenrollment from the managed care program. Failure to follow these policies will result in no payment to the hospice provider for those dates that the IHCP member was enrolled in managed care.

  Effective September 15, 2003, the hospice provider must send the HCE Prior Authorization Unit the hospice election form by 4 p.m. Indianapolis time to ensure that HCE can coordinate with Americhoice to provide ample time to disenroll the hospice member on that same day along with their overall workflow.