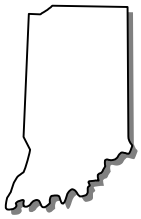

IMPORTANT INFORMATION

BR200332 AUGUST 12, 2003

To All Providers:

- The Indiana Heath Coverage Program (IHCP) provider bulletin BT200346 published July 2, 2003, stated that "A provider can bill a member for copayments only." The use of the term "copayments" in this publication refers to Medicaid copayments, and not commercial copayments required by third party insurers. Under certain circumstances, providers are allowed to collect Medicaid copayments from members, for services such as, non-emergency services provided in an emergency department, pharmacy, and transportation. However, the IHCP providers cannot bill IHCP members for any portion of a copayment imposed by a third party insurer. For additional information about Medicaid copayments, refer to Chapter 2, Section 7 of the IHCP Provider Manual.
- IHCP provider bulletin *BT200346* published July 2, 2003, advised providers that member fraud can be reported to the Medicaid Fraud Unit; however, member fraud should be reported to either the Indiana Division of Family and Children Public Fraud Hotline at 1-800-446-1993 or Health Care Excel Provider and Member Concern Line at (317) 347-4527 or 1-800- 457-4515. The Medicaid Fraud Control Unit addresses issues of provider fraud.
- On April 8, 2003, providers were notified in an article in banner page, *BR200314*, that a review of claims preprocessing history for procedure code *90999-Unlisted Dialysis Procedure in Hospital or Outpatient* determined that Medicare secondary claims for dialysis were not reimbursing according to the 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 procedure 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 procedure code 90935 that is $72.64. On May 19, 2003, EDS scheduled a systematic adjustment of all claims reimbursed at the greater rate for procedure code 90999 that were submitted over the previous 36 months. The adjustment was delayed until the week of August 11, 2003. This adjustment may result in accounts receivable, on the provider's financial statement.
- 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.

To All Nursing Facility Providers:

- Pursuant to *405 IAC 1-14.6-4(a)* each provider shall submit an annual Medicaid financial report not 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.**

  Failure to submit the Medicaid, and the Medicare written and electronic cost reports within the time limits shall result in the following actions pursuant to *405 IAC 1-14.6-4(e;*

  - No rate review shall be accepted or acted upon until the delinquent reports are received.
  - When an annual financial report or a written and ECR file copy of the Medicare cost report that covers the most recently completed historical reporting period **is more than one calendar month past due,** the rate then currently being paid to the provider **shall be reduced by ten percent,** effective on the first day of the seventh month following the provider's fiscal end and shall so remain until the first day of the month after the delinquent reports are received by the office.
  - The provider **cannot** recover reimbursement lost because of the penalty.

To All Hospice Providers:

- *State Form 51098 (3-03)/OMPP 0014 Hospice Authorization Notice for Dually-Eligible Medicare/Medicaid Nursing Facility Residents* was logged into the inventory at the State Forms Distribution Center on July 30, 2003. The State Distribution Center has informed the IHCP that a written request for State forms will be processed within 24 hours of receipt Monday through Friday.

  IHCP hospice providers may not have access to the new form on August 1, 2003. In an effort to ease the transition, the IHCP will not impose any penalties for untimely submission as noted in *405 IAC 5-34-4* for dually-eligible Medicare/IHCP hospice members residing in nursing facilities for the time period starting August 1, 2003 through September 14, 2003. This grace period will provide time for hospice providers to obtain the *State Form 51098 (3-03)/OMPP 0014* from the State Distribution Center, and began following the procedures outlined in *Section 3* of the *IHCP Hospice Provider Manual*. Providers are reminded that the penalty for untimely filing will still be applied to hospice authorization requests for Medicaid-only hospice members effective August 1, 2003.

  Hospice providers that do not have *State Form 51098 (3-03)/OMPP 0014*, but wish to have no interruption in the hospice authorization process may continue to submit hospice authorizations to HCE by following the guidelines that are already in place.

  Effective September 15, 2003, HCE Prior Authorization Unit should receive State Form 51098 (3-03)/OMPP for authorizations of all dually-eligible Medicare/IHCP hospice members residing in nursing facilities. Furthermore effective September 15, 2003, HCE must receive all hospice authorizations for dually-eligible Medicare/IHCP hospice members residing in nursing facilities within 10 business days of the start of each hospice benefit period to be in compliance with *405 IAC 5-34-4*.

  The IHCP has forwarded a PDF file, of *State Form 51098 (3-03)/OMPP 0014* to the Indiana Hospice and Palliative Care Organization, Inc., and the Association for Home and Hospice Care on July 30, 2003. Both associations have distributed the form to members.

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 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.