IMPORTANT INFORMATION

BR200409 MARCH 2, 2004

To All Providers:

- Effective February 1, 2004, remittance addresses for non-pharmacy and TPL refunds changed. To correct billing errors and satisfy accounts receivables, please remit non-pharmacy and TPL refund checks to: EDS Refunds, P.O. Box 2303, Dept. 130, Indianapolis, IN 46206-2303. You must include the department number on the address. If you submit refund checks to a different P.O. Box than listed above or without the department number, processing of your checks and adjustments will be delayed. The mailing address for non-cashed Indiana Health Care Programs (IHCP) checks remains unchanged. EDS Finance Department, 950 North Meridian Street, Suite 1150, Indianapolis, IN 46204-4288.
- Medical crossover claims on remittance advices (RA) dated January 6, 2004, and January 13, 2004, that have posted explanation of benefits (EOB) 4033 – *Invalid procedure code and modifier combination* reportedly denied. Claims that previously denied with this EOB are being evaluated and will be reprocessed, if necessary, beginning March 4, 2004, and conclude March 11, 2004.
- Providers that are submitting claims electronically and have upgraded to Health Insurance Portability and Accountability Act (HIPAA) compliant software must use their newly assigned production identification (ID) numbers to send claims. Providers that have been assigned new production ID numbers will have two weeks from the date the production ID numbers are sent to move to the HIPAA compliant format. EDS will begin disabling old login ID numbers beginning March 8, 2004. For additional information call EDS Electronic Solutions at (317) 488-5160 in the Indianapolis local area or at 1-877-877-5182. EDS Electronic Solutions can also be contacted by e-mail at INXIXTradingPartner@eds.com
- Medical claims and Medicare Part B claims on remittance advices (RA) dated January 6, 2004, and January 13, 2004, that have posted explanation of benefits (EOB) *4209 – No pricing segment for procedure code and modifier combination* may have been reimbursed incorrectly. Claims that adjudicated with EOB 4209 and created an underpayment have been corrected. Claims that denied inappropriately were mass adjusted and reprocessed and appear on the RA dated February 24, 2004.
- The purpose of this article is to inform pharmacies and prescribing physicians that when prior authorization (PA) cannot be immediately obtained, a pharmacist can dispense at least a 72-hour supply of a covered outpatient drug. The Indiana Health Coverage Programs (IHCP) will reimburse if, subsequent to dispensing in an emergency situation, the claim form indicates the supply was for an immediate need.
  To allow for holidays and times when PA offices are closed, the IHCP policy for emergency situations states that pharmacies can be paid for claims submitted for a maximum of a four-day supply of a covered outpatient drug without prior authorization.
  For packaging that cannot be broken down to a four-day or less supply, for example, metered dose inhalers, pharmacies are advised to dispense the smallest quantity possible that is adequate for the emergency situation. The provider should document that the quantity given was the least that could be dispensed because of manufacturer packaging constraints while meeting the needs of the patient during an emergency.
  All emergency claims, paper and electronic, should be submitted with the level-of-service being *03 – Emergency Indicator* and the actual days supply being dispensed up to, but not exceeding four days.

To Acute Care Hospitals:

- The IHCP bulletin, *BT200360,* published September 16, 2003, contained a list of recalibrated diagnosis-related group (DRG) relative weights and average lengths of stay for claims incurred on or after November 1, 2003. The bulletin also indicated that a new version of the AP-DRG grouper was to become effective November 1, 2003. Several new DRGs were introduced in the bulletin, as well.
  There was one new DRG omitted from the bulletin and the system. The table below lists information that is effective for inpatient hospital claims incurred on or after November 1, 2003. Providers may wish to adjust paid claims that grouped to DRG 109 with dates of service on or after November 1, 2003.

DRG	Description	Weight Before 11/01/03	ALOS Before 11/01/03	Weight After 10/31/03	ALOS After 10/31/03
109	Coronary bypass w/o ptca w/o cardiac cath	NA	NA	4.629	9.0

To Home Health Providers:

- Prior authorizations (PA) submitted to request nursing services should reflect the appropriate home visit nursing code. PAs for nursing requests do not need to indicate whether a registered nurse (RN) or a licensed practical nurse (LPN) will perform the service because that level of detail is reported on the UB-92 paper claim or the 837 institutional electronic transaction.
  The IHCP issues PA for home health nursing based on procedure code 99600 TD – *Unlisted home visit or service, registered nurse*. Home health providers may bill either 99600 TE – *Unlisted home visit or service, LPN or LVN*, or 99600 TD. Indiana*AIM* will use the approved PA units for the RN service 99600 TD.
  For PA requests that have been already submitted with the 99600 TE, IHCP will automatically switch the approved units to the 99600 TD code combination.

To Transportation Providers:

- Local procedure code Y9010 - *Non-emergency transportation; taxi suburban* was end-dated in IHCP provider bulletin,*BT200353*, published August 15, 2003, IHCP has created replacement procedure code and modifier combination A0100 U4 to replace local code Y9010.
  - A0100 – Non-Emergency Transportation; taxi

– U4 – Non-Emergency Transportation; taxi, suburban, when billed with procedure code A0100, modifier U4, will reflect this definition. Trips that are within the jurisdictional suburban territory are to be billed under procedure code A0100 U4 – *Non-emergency transportation, taxi-suburban territory*. Using the provider's usual and customary rate. The metered or zoned rate is capped at $15.00. Providers are to bill one unit of service for each one-way trip the recipient is transported.

The IHCP has revised the billing requirements for taxi services using the following procedure code and modifier combinations effective for dates of service January 1, 2004, and after.

Claims submitted for dates of service on or after January 1, 2004, should be billed with procedure code and modifier combination outlined below. The order of the modifiers does not affect claims payment or processing.

Procedure code/modifier	Procedure code/modifier description	Billing instructions
A0100 UA	Taxi, rates non-regulated, 0-5 miles	Bill one unit of service for each one-way trip of 0-5 miles
A0100 UB	Taxi, rates non-regulated, 6-10 miles	Bill one unit of service for each one-way trip of 6-10 miles
A0100 UC	Taxi, rates non-regulated, 11 miles and up	Bill one unit of service for each one-way trip of 11 or more miles
A0100 UA TK	Taxi, rates non-regulated, 0-5 miles for accompanying parent/attendant	Bill one unit of service for each one-way trip of 0-5 miles with an accompanying parent/attendant
A0100 UB TK	Taxi, rates non-regulated, 6-10 miles for accompanying parent/attendant	Bill one unit of service for each one-way trip of 6-10 miles with an accompanying parent/attendant
A0100 UC TK	Taxi, rates non-regulated, 11 miles and up for accompanying parent/attendant	Bill one unit of service for each one-way trip of 11 or more miles with an accompanying parent/attendant
A0100 UA TT	Taxi, rates non-regulated, 0-5 miles for multiple passengers	Bill one unit of service for each one-way trip of 0-5 miles for multiple passengers
A0100 UB TT	Taxi, rates non-regulated, 6-10 miles for multiple passengers	Bill one unit of service for each one-way trip of 6-10 miles for multiple passengers
A0100 UC TT	Taxi, rates non-regulated, 11 miles and up for multiple passengers	Bill one unit of service for each one-way trip of 11 or more miles for multiple passengers

The mass adjustment of claims with procedure code A0100 published in IHCP banner page, *BR200406*, published February 10, 2004, will be reprocessed the week of March 1, 2004, and will appear on a forthcoming remittance advice. All claims were not identified in the first mass adjustment that included A0100 TK and TT. Providers should resubmit using the procedure codes identified above beginning March 12, 2004, unless your claim denied with the previous mass adjustment at which point you can bill now. Providers should follow the procedure code and modifier combination indicated in table above when billing with these modifiers.

Additionally, all PA requests for A0100 UA-UC, A0100 TT UA-UC, and A0100 U4 should be submitted under the global code A0100 without the modifiers. Providers were told to submit the specific procedure code and modifier combination. In an effort to simplify the PA submission process for these requests providers should only submit the A0100 procedure code. The Indiana*AIM* system will read and decrement PA units for these procedure codes from the A0100 code. The documentation must support mileage or trips billed; all trips are subject to post payment review.

To Hospice Providers:

- Effective March 1, 2004, the IHCP will issue expenditure payouts for the following scenarios in which a hospice provider admits a member enrolled in Managed Care Organization (MCO) to their hospice program:
  - Weekend admissions where the member dies during the weekend and the hospice provider could not fax the IHCP hospice election form to HCE PA Unit since HCE is closed until Monday morning or in the case of holidays the following business day. The hospice provider must still meet the timeliness requirement of faxing the IHCP hospice election form on the first possible business day by the 4 p.m. deadline outlined in the IHCP banner page article, *BR200329*, published July 22, 2003. For example, if the patient was admitted on Friday at 8 p.m., the IHCP hospice election form must be faxed to HCE on the following Monday prior to the 4 p.m. deadline.
  - Admissions to the hospice program where the member dies on the day of admission and HCE could not have disenrolled the member even if the hospice provider faxed the IHCP hospice election form to HCE the day of admission.

  In order to meet the parameters for the expenditure payout, the hospice provider must be able to produce a copy of the Medicaid eligibility verification strip that demonstrates that the hospice provider checked eligibility upon admission per the IHCP Provider Agreement, the Medicaid hospice election form and other paperwork must be faxed to HCE on the first available business day so that HCE can perform a review for medical necessity, and the hospice provider must complete the UB92 Claim form so that the OMPP may request that EDS issue an expenditure payout. HCE will notify an appropriate OMPP contact regarding each expenditure payout situations and the OMPP will then contact the hospice provider regarding the required documentation.
- Hospice providers were instructed in the IHCP provider bulletin, *BT200372,* published December 15, 2003*,* that effective February 1, 2004, that there would be changes to the hospice authorization process that would require providers to use an *Indiana Prior Review and Authorization Request Form* as a cover sheet for all hospice authorization requests. This bulletin further notifies providers that they must start completing a *System Update Form* and attach it to the front of the following four forms:
  - Hospice Provider Change Request Between Hospice Providers
  - Change in Status of Medicaid Hospice Patient Form
  - Medicaid Hospice Revocation
  - Medicaid Hospice Discharge Form

  The *Indiana Prior Review and Authorization Request Form* and the *System Update Form* can be obtained on the IHCP Web site at www.indianamedicaid.com under the forms and publications link at the top of the home page, or the form link at the right side of the home page.