IMPORTANT INFORMATION

BR200410 MARCH 9, 2004

To All Providers:

- Medical claims that have posted explanation of benefits (EOB) 6653 – *Postoperative medical visits performed within 90 days of surgery are payable only for a surgical complication and if documented as medically indicated. Documentation not present or does not justify the visit billed* may have been reimbursed incorrectly. The issue relating to adjudicated claims posting EOB 6653 and creating underpayments has been corrected. Processing for claims that have denied inappropriately will be mass adjusted and reprocessed beginning the week of March 9, 2004.
- 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.
- 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.

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 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.

To Acute Care Hospitals:

- *House Enrolled Act 1487,* 2001 Indiana General Assembly, requires the Office of Medicaid Policy and Planning (OMPP) to reimburse hospitals for newborn screening fees assessed by the State Department of Health (SDH). Effective January 12, 2004, the SDH promulgated a rule that increased the fee by $23. Prior to January 12, 2004, OMPP updated the neonatal DRG relative weights to reflect these additional costs. Please refer to Table 1 below for a list of diagnosis-related groups (DRG) and relative weights effective for claims incurred on or after January 12, 2004.

Table 1 – IHCP Diagnosis-Related Group (DRG) Relative Weights for Newborns

DRG	DRG Description	Old DRG Weight	New DRG Weight 01/12/04
602	Neonate, birthwt <750g, discharged alive	23.4874	23.4953
603	Neonate, birthwt <750g, died	9.0066	9.0142
604	Neonate, birthwt 750-999g, discharged alive	15.6219	15.6299
605	Neonate, birthwt 750-999g, died	11.1360	11.1433
606	Neonate, birthwt 1000-1499g, w signif or proc, discharged alive	14.3460	14.3534
607	Neonate, birthwt 1000-1499g, w/o signif or proc, discharged alive	9.0640	9.0721
608	Neonate, birthwt 1000-1499g, died	11.2357	11.2427
609	Neonate, birthwt 1500-1999g, w signif or proc, w mult major prob	8.8085	8.8167
610	Neonate, birthwt 1500-1999g, w signif or proc, w/o mult major pro	4.2562	4.2640
611	Neonate, birthwt 1500-1999g, w/o signif or proc, w mult major pro	6.9132	6.9213
612	Neonate, birthwt 1500-1999g, w/o signif or proc, w major prob	4.1007	4.1088
613	Neonate, birthwt 1500-1999g, w/o signif or proc, w minor prob	3.0142	3.0224
614	Neonate, birthwt 1500-1999g, w/o signif or proc, w other prob	1.5772	1.5854
615	Neonate, birthwt 2000-2499g, w signif or proc, w mult major prob	5.2356	5.2435
616	Neonate, birthwt 2000-2499g, w signif or proc, w/o mult major pro	1.3651	1.3733
617	Neonate, birthwt 2000-2499g, w/o signif or proc, w mult major pro	3.7485	3.7566
618	Neonate, birthwt 2000-2499g, w/o signif or proc, w major prob	1.9994	2.0075
619	Neonate, birthwt 2000-2499g, w/o signif or proc, w minor prob	1.6691	1.6772
620	Neonate, bwt 2000-2499g, w/o signif or proc, w norm newborn diag	0.4322	0.4404
621	Neonate, birthwt 2000-2499g, w/o signif or proc, w other prob	1.2711	1.2793
622	Neonate, birthwt >2499g, w signif or proc, w mult major prob	9.1618	9.1692
623	Neonate, birthwt >2499g, w signif or proc, w/o mult major prob	2.7665	2.7741
624	Neonate, birthwt >2499g, w minor abdom procedure	0.9815	0.9892
626	Neonate, birthwt >2499g, w/o signif or proc, w mult major prob	2.2646	2.2725
627	Neonate, birthwt >2499g, w/o signif or proc, w major prob	0.9089	0.9170
628	Neonate, birthwt >2499g, w/o signif or proc, w minor prob	0.5941	0.6022
629	Neonate, bwt >2499g, w/o signif or proc, w normal newborn diag	0.2421	0.2503
630	Neonate, birthwt >2499g, w/o signif or proc, w other prob	0.5460	0.5542
631	Bpd and oth chronic respiratory diseases arising in perinatal per	1.0040	1.0118
633	Multiple, other and unspecified congenital anomalies, w cc	2.1358	2.1436
634	Multiple, other and unspecified congenital anomalies, w/o cc	2.1785	2.1853
635	Neonatal aftercare for weight gain	1.6481	1.6481
636	Infant aftercare for weight gain, age >28 days <1 year	2.3119	2.3119
637	Neonate, died w/in one day of birth, born here	0.5120	0.5202
638	Neonate, died w/in one day of birth, not born here	2.1192	2.1274
639	Neonate, transferred <5 days old, born here	0.2552	0.2634
640	Neonate, transferred <5 days old, not born here	0.9272	0.9352
641	Neonate, birthweight >2499g, w ecmo	20.2211	20.2286

Please refer questions about this information to Ryan Farrell of Myers and Stauffer at (317) 846-9521 in the Indianapolis local area or 1-800-877-6927, or by e-mail at rfarrell@mslc.com.