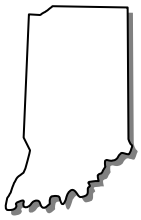

IMPORTANT INFORMATION

BR200424 JUNE 15, 2004

To All Providers:

- As a reminder, EDS changed banks from Huntington National Bank to Fifth Third Bank effective January 1, 2004. Provider checks issued before January 1, 2004 will stale date on July 1, 2004. In order to prevent checks issued prior to January 1, 2004, from stale dating, providers must present them prior to July 1, 2004.
- Effective October 16, 2003, state-assigned occurrence codes 50-69 were discontinued due to HIPAA requirements. In the interim, IHCP will continue to use these non-HIPAA codes on UB-92 paper claim forms and 837I electronic transactions until an alternative method of processing claims requiring these codes has been established. The IHCP is establishing new billing requirements for claims affected by the elimination of these codes. Providers will be notified of the new billing requirements when they have been established.
- In the April 2003, Version 4 of the Provider Manual, Table 8.60, "Antepartum Tests and Screenings Schedule," incorrectly lists HCPCS code 81025 – *Urine pregnancy test, by visual color comparison methods* to be performed at each prenatal visit during trimesters one, two and three. Like other urinalysis, the use of the automated urinalysis is to be based on medical necessity as determined by the physician.

  For example, if there is no suspicion of a urinary tract infection, the correct code is CPT code 81002 – *Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated without microscopy.* Or, if a urinary tract infection is suspected, the correct code is CPT code 81000 – *Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated with microscopy.* Other options for urine screening are CPT code 81001 – *Urinalysis, automated with microscopy* or CPT code 81003 – *Urinalysis, automated without microscopy.*

  If you have any questions or concerns, contact your provider representative.
- Effective June 1, 2004, the Indiana Health Coverage Programs (IHCP) has implemented changes to the eligibility verification system (EVS). These changes have resulted in the ability of chiropractic, dental, and durable medical equipment (DME) providers to inquire about additional benefit limitations, and for all providers to receive additional level of care information in the eligibility response system. In addition, nursing home residency information and the level of care information provided by the EVS will also identify hospice or waiver level of care. For in-depth articles about this EVS update, please refer to the *IHCP Monthly Newsletter* published May 15, 2004.

  The automated voice response system (AVR) and Web interChange will be updated automatically with no provider action required. Providers using the OMNI system must download new OMNI software available June 1, 2004, that includes these updates. Complete download instructions are available in IHCP provider bulletin, *BT200303,* published January 31, 2003, and are available at www.indianamedicaid.com. Providers using other software packages for batch or other interactive 270/271-eligibility verification must contact their software vendors to ensure that the correct software is being used.

  Providers requiring specific information about dates of each level of care segment and the specific type of hospice or waiver assignment must contact the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. If a specific level of care cannot be identified for the period searched, providers may contact Health Care Excel (HCE) for hospice level of care or the waiver or long-term care units at the OMPP for the appropriate information.
- Electronic Funds Transfer (EFT) is the ability to accept Indiana Health Coverage Programs (IHCP) payments by direct deposit into a provider's designated bank account. The EFT is accomplished using Automated Clearing House (ACH) transactions from the IHCP's bank, Fifth Third Bank, to the provider's bank. Providers wanting to use the 835 Health Care Claim Payment Remittance Advice transaction along with their electronic ACH payment file from their bank to reconcile their accounts have been unable to perform this functionality due to required changes in the ACH format. Effective June 7, 2004, the IHCP has modified the ACH file that is sent to Fifth Third Bank to include the ACH addenda record per the recommendation outlined in the 835 Implementation Guide. Providers can choose to accept the ACH addenda record from their bank. This will not affect electronic payments for those providers who do not require or choose not to receive the ACH addenda record. The 835 remittance advice Companion Guide will be modified to include the ACH value in BPR04 and CCP in BPR05 when the provider has EFT and also receives the 835 electronic remittance advice transaction. Refer to www.indianamedicaid.com for the current copy of the 835 Remittance Advice Transaction Companion Guide.

  EFT payments significantly decrease the provider's administrative processing that is required by paper checks. EFT is safe and only allows the deposit of funds into a designated account and eliminates lost, misplaced, voided, and stale-dated checks. EFT payments can be established on a billing provider number by submitting a completed EFT form to EDS Provider Enrollment. The form is available to download at www.indianamedicaid.com or by calling Customer Assistance. For more information about establishing EFT payments, contact Customer Assistance at 317-655-3240 in the Indianapolis local area or 1-800-577-1278.

To Hospice Providers:

- Effective July 1, 2004, hospice providers will be required to modify the way they bill for the date of death. When billing a date of service that is the same as the date of death (for those recipients residing in a Nursing Facility), hospice providers will bill occurrence code 51 in field 32a on the UB 92 claim form, along with the date of death. The system has been modified to no longer pay for the date of death for hospice services for those recipients residing in Nursing Facilities. However, by billing occurrence code 51 with the date of death, the system will only pay for hospice services for the date of death for revenue codes 653 and 654. Without occurrence code 51, providers will receive EOB 9069 – *Room and Board not paid on date of death/discharge*, when they bill revenue codes 653 or 654 for date of death. Without occurrence code 51, the system will deny revenue code 659 if it is the same date as the date of death. Providers will receive EOB 4233 – *Date of death/discharge not covered*, when they bill revenue code 659 for date of death. For questions, please contact Customer Assistance at (317) 655-3240 or 1-800-577-1278.

To Medical and Home Health Providers:

- Medical and Home Health claims did not process as expected with posted explanation of benefits (EOB) *3001 – Dates of service not on PA master file* or with an EOB associated with a specific benefit limit where the claim denied because a prior authorization was on file. The issue relating to adjudicated claims that created underpayments between May 25, 2004 and June 8, 2004, has been corrected. Therefore, claims that were adjudicated between the aforementioned time period will be reprocessed and mass adjusted beginning on the June 15, 2004, remittance advice (RA) statement.

To Medical Providers:

- Medical claims that have posted explanation of benefits (EOB) 4033 – *Invalid procedure code/modifier combination*, 4209 – *No pricing segment on file for the procedure code/modifier billed*, and 4203 – *Denial modifier for non-covered MRO services*, may have been reimbursed incorrectly. The underpayments and potential overpayments issue relating to adjudicated claims posting edit 4033, 4209, and 4203 has been corrected. Therefore, claims that were adjudicated with a modifier in the first, second, or third modifier position that processed between May 25, 2004 and June 4, 2004 will be reprocessed and will appear beginning on the June 15, 2004, remittance advice (RA) statement. Mass adjusted claims will begin appearing on the August 17, 2004, remittance advice (RA) statement.

To Transportation Providers:

- Transportation claims submitted with procedure code A0130 – *Non-emergency transportation; wheelchair van*, for dates of service January 1, 2004, through April 15, 2004, may have been paid incorrectly up to $30 per unit. Procedure code A0130, as documented in IHCP provider bulletin *BT200353*, dated August 15, 2003, is to be reimbursed at $20 per unit.

  Affected providers will be notified of the overpayment amount and the number of claim details by letter. The provider notification letter will detail the timeframe for the mass adjustment for the provider's specific claims. The IHCP will systematically mass adjust all affected claims starting June 9, 2004.

To Inpatient Hospital Providers:

- Inpatient claims may have posted explanation of benefits (EOB) code *5007 – This is a duplicate of another claim. If this claim was intended to be an adjustment, please submit the appropriate adjustment request form*. These claims may have been adjudicated incorrectly. The issue relating to claims posting EOB 5007, which created underpayments as well as incorrect denials, has been corrected. Identified claims that were processed between March 31, 2004 and May 26, 2004, will be mass adjusted and reprocessed. The affected claims will appear beginning on the June 15, 2004, remittance advice (RA).