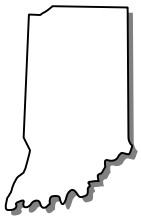

IMPORTANT INFORMATION

BR200427 JULY 6, 2004

To All Providers:

- The Indiana Health Coverage Programs (IHCP) continues to assist and improve processes on behalf of the provider community. In order to assist providers using paper claims, providers should be informed that through research, the IHCP has discovered some root causes that delay processing and increase errors in processing paper claims. Providers may want to adjust their paper claim billing process to implement the following practices:
  - Submit paper claims on standard Centers for Medicare and Medicaid Services (CMS) approved redlined claim forms.
  - Use the following fonts when printing: Helvetica, Times Roman, or Courier at 12 point or 14 point font size.
  - Do not hand-write information on claim forms.

  For questions concerning this information, contact Customer Assistance at 317-655-3240 in the Indianapolis local area or 1-800-577-1278.
- The IHCP has received questions from trading partners about comparisons between the paper remittance advice (RA) and the 835 electronic transaction. The paper RA reports only dollar amounts without balancing concerns. This dollar amount reflects prior payment information including spend-down, third party liability (TPL), and Medicare payments; or Medicare co-insurance or deductible as submitted with the original claim. There are different methods of reporting adjustments in the CAS segments of the 835 transaction. *Per the Data Overview Section of the 004010X091 – 835 – Health Care Claim Payment/Advice Transaction, Version 4010 Implementation Guide and the 4010A1 Addenda, Section 2.1.4 – Remittance,* "The 835 must be balanced whenever remittance information is included in an 835 transaction." *Section 2.2.1 – Balancing*, in the same section of the 835 implementation guide states "The amounts reported in the 835, if present, MUST balance at three different levels." Because the guide does not address the issue of populating the 835 CAS segments, the decision was made to use the method described in the 4050 draft version of the 835 guide. Per this guide, the IHCP will only report for balancing purposes the amount of prior payment, spend-down, TPL, and Medicare payments, or Medicare co-insurance or deductible in the 835 transaction up to the amount that would have been paid for the service.

  The intent of this approach is to minimize the risks of future changes with newer versions of the 835 transaction. There are no planned changes to the paper RA or 835 transaction at this time. For a technical example of the IHCP 835 transaction adjustment information related to the balancing methodology identified in the 4050 draft version of the 835 guide, please refer to the Frequently Asked Questions within EDI Solutions of the IHCP Web site.
- The *HealthWatch Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)* provider manual for immunization and screening table incorrectly lists Current Procedural Terminology (CPT) code 80100 for HIV testing and screening. The following CPT codes should be used for this procedure:
  - 86701 – HIV-1
  - 86689 – HIV antibody confirmatory test (e.g., Western Blot)

  This correction will be reflected in the next revision of the *HealthWatch/EPSDT* provider manual. Please direct any questions to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1228.
- The IHCP has removed postoperative pain management codes, CPT codes 62310, 62311, 62318, 62319, 64412-64417, 64420, 64421, and 64445-64450, from audit *6666 – Anesthesia services not allowed by provider billing for surgery.* Claims submitted with anesthesia procedure codes and these procedure codes should now reimburse appropriately. Modifier *59 – Distinct procedural service*, should be used in conjunction with postoperative pain management codes billed on the date of surgery.

To Pharmacy Providers:

- Effective June 30, 2004, the State Maximum Allowable Cost (SMAC) rate for the following drug group will be updated.

Group	Drug Group Name	SMAC
413	TRIFLUOPERAZINE 5MG TABLET	.6371

Please direct questions concerning the SMAC to the Myers and Stauffer Pharmacy Unit at 317-846-9521 or 1-800-877-6927, or by e-mail at pharmacy@mslc.com.

- The Drug Utilization Review (DUR) Board has approved the following change to the preferred drug list (PDL). Effective August 17, 2004, all ciprofloxacin generic products will be considered a preferred drug on the PDL. As a reminder, all non-preferred products will reject with edit code *3017 – NDC not on preferred drug list*. Please refer to IHCP provider bulletin *BT 200132,* published August 10, 2001, for more information on brand medically necessary. Prescribers may request a prior authorization (PA) by calling the ACS Clinical Call Center at 1-866-879-0106.

To Home Health Providers:

- The purpose of this article is to clarify billing units of home health visits for therapists, home health aides (HHA), license practical nurses (LPN), and registered nurses (RN).
  - For therapy visits – If the therapist is in the home eight minutes or more, then the visit can be rounded up to the 15-minute unit of service. If the therapist is in the home for seven minutes or less, this cannot be rounded up and therefore cannot be billed.
  - For HHA, LPN, or RN visits – If the HHA, LPN, or RN is in the home for less than 29 minutes, the entire first hour can be billed. This can only be done if a service was provided. For subsequent hours in the home, use the partial unit procedure as outlined in the *IHCP Provider Manual,* chapter 8, section 8, page 42. For example: If an RN went into the home and a service was provided, but the RN was only there for 20 minutes, you may bill one unit of service. If the RN went into the home and was there for one hour and 20 minutes, you may only bill for one unit of service.

If the therapist, HHA, LPN, or RN goes to the home and the member refuses service, the provider may not bill for any unit of service. Overheads are linked with reimbursement for services provided. Since a service was not provided, an overhead cannot be reimbursed.

To Transportation Providers:

- Transportation providers may have experienced claim payments for HCPCS code *A0130 – non-emergency transport*, where adjudication of the claim resulted in no deduction of the copay amount. The required system change for A0130 to deduct the appropriate copay amount has been completed; therefore claims submitted on or after June 2, 2004, will begin deducting the copay amount. There will not be any reprocessing or mass adjustment of affected claims.
- Transportation claims submitted with procedure code A0130 TT – *Non-emergency transportation; wheelchair van, individualized service provided to more than one patient in same setting (multiple passenger),* for dates of service starting January 1, 2004, may have paid incorrectly up to $20 per unit. Procedure code A0130 TT, which is the replacement for local code Y9201, should be reimbursed at $10 per unit.
  The reimbursement rate was changed from $20 to $10 on June 18, 2004, and the $10 rate will be made retroactive to January 1, 2004. The rate was incorrectly reported in IHCP provider bulletin, *BT200353,* published August 15, 2003. The IHCP will systematically mass adjust all affected claims in the near future and providers will be notified in advance. Most providers will notice only one RA affected by this mass adjustment process. However, some providers may be notified in advance if the process will require additional time.