IMPORTANT INFORMATION

BR200449 DECEMBER 7, 2004

To All Providers:

- The next Indiana Health Insurance Portability and Accountability Act (HIPAA) Workgroup meeting is on Thursday, December 16, 2004, at the downtown Indianapolis AUL building from 9 a.m. to 11 a.m. The agenda will feature a demonstration of the HIPAA Convergence Project. The HIPAA Convergence Project enables the healthcare industry to compare transaction requirements among payers, content committees such as NUCC and NUBC, and industry associations. For more information please log onto www.indianahipaa.org.

- The Office of Medicaid Policy and Planning (OMPP) will hold a series of public meetings on the transition to mandatory risk-based managed care in southern Indiana. The details of the next scheduled public meeting on the transition to mandatory risk-based managed care is as follows:
  - Lawrence and Monroe Counties area public meeting: The meeting will be held from noon to 1 p.m. on January 6, 2005, at Bloomington Hospital's Wegmiller Auditorium, 601 West Second Street, Bloomington, IN. The agenda will include a brief presentation from OMPP and all the Managed Care Organizations (MCO) will be available to answer questions.

- On December 1, 2004, the Indiana Health Coverage Programs (IHCP) will begin accepting Medicare crossover claims for diabetic test strip procedure codes with dates of service that span 90 days. Providers may use Web interchange to submit these claims electronically at that time. Claims for spend-down members that require a *DPW Form 8A* , must have the *DPW Form 8A* attached for only the first month in the span of dates of service. If billing on paper, the *DPW Form 8A* must be attached to the claim. If billing electronically, the *DPW Form 8A* must be sent through the attachment process. Claims that crossover from Medicare will generate a claim correction form (CCF) for the attachment. For example, a claim is submitted for dates of services spanning from October 1, 2004, to December 1, 2004. If the DPW Form 8A is required for processing, the provider must submit a DPW Form 8A for October, not November and December.
  Listed in the table below are the procedure codes and descriptions that will be affected:

Procedure Code	Description	Procedure Code	Description
A4244	Alcohol or peroxide, per pint	A4254	Replacement battery, any type, for use with medically necessary home blood glucose monitor
A4245	Alcohol wipes, per box	A4255	Platforms for home blood glucose monitor, 50 per box
A4246	Betadine or phisohex solution, per pint	A4256	Normal, low and high calibrator solution/chips
A4247	Betadine or iodine swabs/wipes, per box	A4257	Replacement lens shield cartridge for use with laser skin piercing device, each
A4250	Urine test or reagent strips or tablets (100 tablets or strips)	A4258	Spring-powered device for lancet, each
A4253	Blood glucose test or reagent strips, per 50 strips	A4259	Lancets, per box of 100
A4253	Billed with modifier NU will now cross over from Medicare.		

- To address an immediate need for immunizations and a shortage of available influenza vaccines, the Indiana Health Coverage Programs (IHCP) is **not** limiting reimbursement for any influenza vaccines, regardless of availability from the Vaccines For Children (VFC) program. This will allow providers to obtain reimbursement for using privately purchased influenza vaccine if they do not have VFC vaccine due to the shortage crisis. When administering privately purchased influenza vaccine, providers may bill for both the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement will include payment for both. NOTE: If you administer free VFC vaccine, bill the appropriate influenza vaccine procedure code but do not charge more than the $8.00 VFC vaccine administration fee. Providers that are enrolled with a managed care organization will continue to submit claims to that MCO. For more information about billing for influenza vaccine, refer to the April 2004 provider monthly newsletter available on the IHCP Web site at www.indianamedicaid.com RHCs and FQHCs, please note: RHC- and FQHC-specific encounter rates already include payment for immunizations. When submitting RHC and FQHC claims to track encounters (note: such claims will be denied), bill no more than the $8 VFC administration fee for use of VFC influenza vaccine **or** bill the usual and customary rate for the influenza vaccine CPT plus the administration CPT 90782 for use of provider-purchased influenza vaccine.

To Home Health Providers:

- Home health providers may have noticed claims denying for edit 6750 – *no more than 30 home health therapy hours within 30 days of hospital discharge*, and edit 6155 – *nursing services and home health aid services are limited to 24 units a day.* These claims may have denied inappropriately. A mass reprocess and adjustment for these claims was completed on the November 30, 2004, remittance advice (RA). Claims with date of services January 1, 2004, through October 31, 2004, were affected by this issue. If you have any questions, please contact customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To Mental Health Providers:

- The IHCP cross walked local codes to the most similar national codes available in order to be HIPAA compliant. It was not the intent of this process to change existing policy. Provider notification IHCP provider bulletin, *BT200353*, published August 15, 2003, lists the cross walk of local code X3040 – *outpatient diagnostic assessment/pre-hospitalization screening*, to national code H0031 HW – *mental health assessment, by non-physician*, one unit equals one-quarter hour, in the Medicaid Rehabilitation Option (MRO) program. The IHCP instructs mental health providers to report H0031 HW for physicians performing mental health assessments in the MRO program. Mid-level practitioners should continue reporting H0031 HW with the appropriate mid-level modifier.
  Direct questions about this article to the HCE Medical Policy department at (317) 347-4500.

- IHCP claims billed with Healthcare Common Procedure Coding System (HCPCS) that have the same three beginning alpha or numeric characters, for the same member, on the same date of service and rendered by the same provider must be specially handled. For example, a claim billed with H0033 HW and H0035 HW, for the same date of service and same rendering provider number will deny as an exact duplicate through normal processing, or a claim billed with H0035 HW and H0035 HW AJ, for the same date of service and same rendering provider number will also deny as an exact duplicate through normal processing.
  To avoid this type of claim denial providers must submit claims, to the address listed below:. EDS will special batch the claims to ensure correct claim processing. EDS will notify providers through an IHCP banner page article once the system is modified to allow claims processing through normal channels.
  Send Claims to:

  EDS Written Correspondence
  P.O. Box 7263
  Indianapolis, In 46207-7263

To Home and Community-Based Services Waiver Providers:

- The purpose of this article is to clarify documentation standards for Home and Community-Based Services (HCBS) Waiver Programs providers rendering services outlined in *BT200305*, published January 15, 2003, and *BT200371*, published December 19, 2003.
  For all services which contain the following documentation requirements: "data record documenting the date of service and the number of units of service delivered that day" or "data record documenting the complete date and time entry (including a.m. or p.m.) and the number of units of service delivered that day" – the intent of the documentation requirement is to record the complete date (mm/dd/yy) and the time in as well as time out. Time in/out must reflect a.m. and p.m. as appropriate, unless your agency chooses to utilize 24-hour clock time notations. Time must be recorded consistently regardless of methodology, either standard time or 24 hour time notation.
  To summarize this clarification, all time bound HCBS Waiver services detailed in the bulletins referenced above must be documented clearly reflecting the complete date (mm/dd/yy) as well as the time in and time out, utilizing either a.m. and p.m. or the 24-hour clock time notation. All documentation entries must reflect the signature of the staff member making the entry, to include at minimum the first initial and last name of the individual along with certification or title, as applicable.
  The above noted procedures are to be implemented immediately. Documentation entries not meeting the above stated criteria will be recouped for all dates of service after December 1, 2004.