IMPORTANT INFORMATION

BR200450 DECEMBER 14, 2004

To All Providers:

- Due to the addition of new Managed Care Organizations (MCOs) in 2005, the Indiana Health Coverage Programs (IHCP) has updated the eligibility verification responses. As of January 1, 2005, the name of the MCO network appears on the eligibility response if the member is assigned to a network within the MCO for the time period of the eligibility request.
  The additional information provided in the eligibility response appears after a second label under the Managed Care section of the response. This label lists the MCO network, if available.
  Beginning January 1, 2005, OMNI terminals will display a second Managed Care Organization segment. This segment will display the MCO network information if available. To change the label verbiage to Managed Care Network, providers must perform an OMNI download. This download is not required in order to receive the MCO network information. The download will only change the name of the segment label.
  Beginning January 1, 2005, automated voice-response (AVR) and Web interChange will provide MCO network assignment information when it is available for dates of service inquiries of January 1, 2005, and after.
  Providers using other forms of eligibility verification, including the 270/271 interactive or batch transactions, must contact their vendor to ensure that the MCO network information can be provided.
  A prerelease 270/271 eligibility benefit transaction companion guide and testing procedures are available in the vendor section of the IHCP Web site under EDI Solutions at www.indianamedicaid.com
- 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 call (317) 614-2139 in the Indianapolis local area or 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.

To Hospital Providers:

- A hospital-specific remittance will be added to the December 14, 2004, claim payment total as indicated in a letter from Myers and Stauffer LC dated November 22, 2004, to qualifying acute care hospitals. This hospital-specific payment amount for state fiscal year ending June 30, 2004, is listed on the financial transaction page of the remittance advice (RA), and is included in the total check amount for the week. Please refer to the *Indiana State Plan Attachment 4.19-A pages 1I – 1M*, effective July 1, 2003, for more information on the Hospital Care for the Indigent (HCI) program.
  The HCI program for SFY 2004 and thereafter, has changed and now requires qualifying acute care hospitals to submit UB-92 claim forms for an approved member for approved time periods to the State HCI Unit in order to receive the additional Medicaid add-on payment. All UB-92 claim forms submitted for a HCI member must include the member's social security number in box 60 of the claim form.

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 Transportation Providers:

- Prior to January 1, 2004 transportation providers were required to submit mileage when traveling over 99 miles utilizing two different procedure codes. As of January 1, 2004, transportation providers are reminded when billing mileage for transportation services in conjunction with base codes of; Advanced Life Support (ALS), Basic Life Support (BLS), Commercial Ambulatory Services (CAS), or Non-Ambulatory Services (NAS) the provider must bill for **all** mileage utilizing the appropriate A0425 mileage code. Mileage should not be fragmented. The total mileage for both the to and from trip should be submitted on one detail line utilizing the appropriate code listed below:

Code	Description
A0425 U1	ALS ground mileage, per statute mile
A0425 U2	BLS ground mileage, per statute mile
A0425 U3	CAS ground mileage, per statute mile
A0425 U5	NAS ground mileage, per statute mile

For example, a provider takes member on an ambulatory (CAS) round trip and travels a total of one hundred and twenty four miles. The table below lists the correct billing procedure.

	Procedure	Code Units
Trip	T2003	2
Mileage	A0425	124

The IHCP performed a review of claims billed utilizing this billing practice and discovered that some providers have billed their claims with multiple mileage codes for the same member, same base, and same date of service. Therefore, deducting 10 miles from each mileage code. The IHCP will systematically mass adjust these claims to correct this underpayment. This mass adjustment should begin to appear on providers remittance advice (RA) on December 28, 2004.
If the provider makes a round trip for the same member, same date of service, and same level of base code, both runs should be submitted on the same detail with two units of service to indicate a round trip. Additionally, the mileage should be billed on the same detail with the total number of miles associated for the roundtrip.
If the provider transports a member on the same date of service, but different trip levels, for example the to trip was a CAS trip, and the return trip was a NAS trip with mileage for each base. These base trips must be billed on two different claims along with the appropriate mileage for each base.
The IHCP performed a review of claims billed utilizing the above billing practice and noted that some providers have been underpaid. The IHCP issued a letter on December 3, 2004, to the affected providers with specific instructions for correcting this situation.