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To All Providers:

- Indiana Health Coverage Programs (IHCP) providers are reminded to review provider bulletin *BT200502* dated February 25, 2005, about changes in spend-down rules. When submitting statements of charges for spend-down purposes, providers must indicate whether they will bill Medicare or other insurance, and the Medicare approved amount for the service, if known.
- This article clarifies the IHCP policy about Healthcare Common Procedure Coding System (HCPCS) codes R0070, R0075, and R0076, in addition to modifiers UN, UP, UQ, UR, and US for the transportation of portable X-ray and electrocardiogram equipment. As of April 15, 2005, HCPCS code R0076 - *Transportation of portable EKG to facility or location, per patient*, is a non-covered service for the IHCP. Providers will no longer be reimbursed for this service. HCPCS code *R0070 -Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen*, is reported for one patient served. HCPCS code *R0070* must not be reported with modifiers UN, UP, UQ, UR, or US. One unit must be reported for the trip. When more than one patient is served, providers must report HCPCS code *R0075 - Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen*, with the appropriate modifier representing the number of patients served. One unit must be reported for the trip. The service must be reported on each member's claim with the appropriate modifier. Reimbursement will be prorated according to how many patients are served, as represented by modifiers UN, UP, UQ, UR, and US. Table 1 lists the percentage of the fee schedule amount that each modifier will reimburse when reported with HCPCS code *R0075*.

Table 1 – HCPCS Code R0075 Modifier Reimbursement

Modifier	Description	Fee Schedule Percentage
UN	Two patients served	50
UP	Three patients served	33
UQ	Four patients served	25
UR	Five patients served	20
US	Six or more patients served	16

Direct questions about this article to Health Care Excel (HCE) Medical Policy Department at (317) 347-4500.

To All Outpatient Hospitals and Ambulatory Surgery Centers:

- The IHCP discovered a payment issue related to outpatient surgeries after implementation of the new outpatient reimbursement policy as stated in IHCP provider bulletin *BT200420*. When providers billed only one surgery or one unit of service, the system calculated the rate at 150 percent instead of 100 percent. This calculation resulted in overpayments. This affected outpatient claims with paid dates from October 5, 2004, through November 9, 2004. Therefore, the IHCP will initiate a systematic mass adjustment for all affected claims. Providers can expect adjusted claims to appear on the remittance advice (RA) statement dated March 8, 2005.

To All HIV Care Coordination Providers:

- This article clarifies IHCP policy for billing HIV care coordination services. Providers must use primary diagnosis code *042 – HIV/AIDS* and procedure code *G9012 – Other Specified Case Management* when billing for HIV and AIDS care coordination services. HIV and AIDS care coordination services are self-referral services under the Hoosier Healthwise and *Medicaid Select* programs. HIV/AIDS care coordination claims are not subject to managed care edits; therefore, there is no requirement for a PMP's certification code and provider number on the CMS-1500 claim form or the 837P transaction. Providers serving members in the RBMC delivery system should contact the appropriate managed care organization for claim filing requirements. Claims previously billed with primary diagnosis code *V689 – Unspecified administrative purpose* and procedure code *G9012 – Other specified case management not elsewhere classified* that denied for managed care edits 342, 343, 1011, 1042, 1043, and 1044 with dates of service January 1, 2004 – December 31, 2004, that were adjudicated prior to March 1, 2005, will be systematically reprocessed. Providers can expect reprocessed claims to appear on the RA statement dated March 15, 2005, or after.