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To All Providers:

- Indiana Health Coverage Programs (IHCP) providers are reminded to review provider bulletin *BT200502* dated February 25, 2005, regarding 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.
- The Office of Medicaid Policy and Planning (OMPP) will implement Hoosier Healthwise mandatory risk-based managed care (RBMC) enrollment across all Indiana counties in 2005. This will transition current Prime*Step* Hoosier Healthwise managed care members from Primary Care Case Management (PCCM) into enrollment with a local managed care organization (MCO) in the RBMC delivery system.

  Primary medical providers (PMPs) in the affected counties can choose to contract with one of the Hoosier Healthwise MCOs. Prime*Step* PMPs who switch to one of the MCOs before the final transition date will retain their current Hoosier Healthwise members. Specialists, hospitals, and ancillary providers may have various MCO arrangements depending on factors such as how many of the MCO's members may be served by the provider, or how many MCOs are serving their region. The transition schedule, regional map, questions and answers, and additional detailed information on the transition can be found in IHCP provider bulletin BT200506, which is available at www.indianamedicaid.com.

  The OMPP will conduct a series of public meetings about the transition to mandatory RBMC for the Hoosier Healthwise program. The meeting's agenda will include an overview of the transition process, individual MCO presentations, and the opportunity to ask questions of the MCOs. The details of upcoming scheduled meetings on the transition to mandatory RBMC are as follows:

  1) Bartholomew County Area Public Meeting: April 5, 2005 at the Columbus Regional Hospital Auditorium (2400 East 17th St., Columbus, Ind.). The meeting will be held from noon to 1 p.m.

  2) Wayne County Area Public Meeting: May 10, 2005 at Reid Hospital Auditorium (1401 Chester Blvd. Richmond, Ind.). The meeting will be held from noon to 1 p.m.

  3) Tippecanoe County Area Public Meeting: To be scheduled.
- Effective April 1, 2005, the IHCP will no longer accept electronic claim transactions that are not compliant with Health Insurance Portability and Accountability Act (HIPAA) requirements. Files received after this date in a non-compliant format will not be processed. Currently, the majority of providers are submitting claims in a HIPAA-complaint format. EDS has been contacting providers and software developers to assist them in becoming HIPAA compliant before this deadline. Providers have the option of using IHCP Web interChange as an alternative method of claims submission. Web interChange can be accessed from the IHCP Web site. Providers should direct questions about the claims submission process to the Electronic Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.
- This article provides updated crossover claim information to educate providers about options available for submitting crossover claims for dually eligible members, or for members covered by private insurance. The following additional information is available on the IHCP Web site at www.indianamedicaid.com.

Table 1 – Crossover and TPL Claims

837 Billing of Crossover Claims to Medicare
837 Billing of Crossover Claims Directly to the IHCP
837 Billing of TPL Claims

Electronic submission of crossover claims decreases the need to submit paper claims, allows for adjudication of claims in a more efficient and timely manner, and eliminates potential keying errors. To increase the volume of electronic claims that automatically cross over from Medicare, the IHCP requests that providers include information needed by the IHCP for adjudication when submitting the 837 electronic transactions to Medicare. Refer to the Billing of Crossover Claims to Medicare link on the IHCP Web site for additional information.

Web interChange and EDI vendor or clearinghouse options are available to providers for claims denied by Medicare, or for claims that do not cross over electronically to the IHCP. Refer to the Billing of Crossover Claims Directly to the IHCP link on the IHCP Web site for additional information.

How to Resubmit a Denied Crossover Claim

Web interChange allows providers to access denied claims and to use the *Copy This Claim* function, which allows providers to make necessary corrections for resubmission of new claims. This function eliminates the need for rekeying the entire claim. Monitor the monthly provider newsletter as well as the IHCP Web site for future updates about submitting crossover claims using Web interChange. Providers should direct questions about this information to the EDI Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182, or by e-mail at INXIXTradingPartner@eds.com.

To All IHCP-enrolled Hospice and Nursing Facility Providers:

- Effective April 1, 2005, hospice providers will not be required to submit individual claim adjustment forms to EDS for retro rate adjustments for room and board payments under the IHCP hospice benefit. System changes have been completed that allow mass adjustments for nursing facility room and board rate of hospice claims billed under bill type 822, and hospice revenue codes 653, 654, 659, 183, and 185. The system change permits hospice claims under the revenue codes listed above to be mass adjusted on the same date that the nursing facility retro rates are mass adjusted. This change will expedite hospice claims payments to contracted nursing facilities. Hospice and nursing facility providers are reminded that mass adjustments to the room and board rate under the IHCP hospice benefit for members residing in nursing facilities will be reflected on the hospice provider's remittance advice (RA). Hospice and nursing facility providers are encouraged to develop coordination and payment procedures to address this retro rate adjustment issue in their contracts.

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 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 electronic 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, through 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.