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To All Providers:

- During the January 2002 Healthcare Common Procedure Coding System (HCPCS) Annual Update, there were several codes that were intended to be non-reimbursable by the Indiana Health Coverage Programs (IHCP). The codes listed on the following table are non-reimbursable, effective January 1, 2002, to the present. Providers should direct questions regarding these procedure codes and coverage to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Table 1 – Non-reimbursable HCPCS Codes Effective January 1, 2002

A4911	S0173	S0187	S0395	S2115	S2402	S3819	S8030	S8450	S9209	S9982
C8910	S0174	S0189	S0400	S2150	S2403	S3830	S8037	S8451	S9211	S9986
S0088	S0175	S0250	S0812	S2250	S2404	S3831	S8055	S8452	S9212	S9989
S0091	S0176	S0255	S1001	S2260	S2409	S3835	S8097	S8490	S9213	S0622
S0092	S0177	S0260	S1002	S2341	S2411	S3837	S8189	S9083	S9214	S1030
S0093	S0178	S0302	S1025	S2342	S3600	S3900	S8190	S9098	S9441	
S0155	S0179	S0310	S1031	S2360	S3601	S4981	S8415	S9109	S9442	
S0170	S0181	S0340	S2065	S2361	S3630	S4989	S8429	S9117	S9443	
S0171	S0182	S0341	S2080	S2400	S3701	S4990	S8430	S9131	S9445	
S0172	S0183	S0342	S2112	S2401	S3818	S4991	S8431	S9208	S9981	

- This article updates information published in IHCP bulletin BT200323 dated May 1, 2003, regarding changes in Chiropractic Services. Effective January 1, 2005, services that meet the fifty (50) unit limitation will post a new Explanation of Benefit (EOB) 6099, which states, "Reimbursement is limited to no more that 50 chiropractic services per member per calendar year. These services could include up to five (5) office visits and spinal manipulation treatments, or physical medicine treatments." Because the chiropractic limitation is applied on a calendar year basis, providers are reminded to bill these services for each calendar year on a separate line item when multiple units for a procedure code span one calendar year to the next.
- The IHCP will allow Current Procedural Terminology (CPT©) code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through iliem, with physician interpretation and report*, to be reported with revenue code 329, *Diagnostic radiology, other*, for outpatient hospital procedures. CPT code 91110 reported with revenue code 329 will reimburse a rate of $520.95 based on the procedure code allowed amount. Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.
- 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.

- The OMPP is participating in a national quality improvement demonstration sponsored by the Centers for Medicare & Medicaid Services (CMS). The demonstration, called the Payment Error Rate Measurement (PERM), will measure and report on the error rate of claim payments by examining supporting documentation for selected claims. This is the OMPP's third year of participation and the final year of the federal demonstration. PERM is scheduled to become a national CMS requirement for State Medicaid programs in October 2005. The OMPP has contracted with Myers and Stauffer, LC, for assistance with this study.

Requested Documentation

The purpose of this bulletin is to inform all enrolled Indiana Health Coverage Program providers that the OMPP and Myers and Stauffer will be requesting information for selected claims in order to study the error rate of traditional Medicaid and Hoosier Healthwise payments. The sample size for the demonstration is modest and many providers will not be asked to participate, though some providers will be asked to submit medical and claim documentation for review. The demonstration will examine both paid and denied claims from October 1, 2004, to December 31, 2004. For each claim selected, any or all of the following information may be requested:

- Medical charts
- Billing information
- Patient notes
- Test orders and results
- Service authorization forms
- Prescriptions
- Provider charge information
- Third party payor information
- Encounter logs
- Any other patient information as deemed necessary by the OMPP to support the amount, scope, and duration of services provided.

Please be advised that under the terms of the provider agreement and participation in the IHCP, providers are required to submit requested documentation. Any submitted information will not be returned. Therefore, it is suggested that copies be submitted rather than original documents. Services that are undocumented or are not sufficiently documented will be counted as an "error" by CMS; therefore, complete and expedient participation when medical and claim documentation is requested is essential to the success of the demonstration. Please also note that neither the OMPP nor Myers and Stauffer will reimburse for copies of any requested documentation. Information collected for this study will be held in strict confidence in compliance with all applicable policies, requirements, regulations, and statutes. By virtue of their contract and Business Associate Agreement with the OMPP, Myers and Stauffer is authorized to have access to Protected Health Information.

Additional Information

Provider cooperation is greatly appreciated. Questions regarding the PERM project or requested documentation may be directed to: **Nedra Moran, RN, Supervisor, Acute Care Services, Myers and Stauffer, LC, 9265 Counselors Row, Suite 200, Indianapolis, Indiana 46240-6419.** Nedra Moran can also be reached at (317) 846-9521 or (800) 877-6927.

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 the nursing facility room and board rates of hospice claims billed under bill type 822 with 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 claim 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.