B A N N E R P A G E

B R 2 0 0 5 5 2 D E C E M B E R 2 7 , 2 0 0 5

To All Providers:

- On January 1, 2006, the Annual Healthcare Common Procedure Coding System (HCPCS) update and the 2005 October and July Quarterly HCPCS updates, which include alphanumeric and Current Procedural Terminology (CPT) codes, will be loaded in Indiana*AIM* with program coverage and pricing determinations. These codes will be available for claims processing on their respective effective dates. To view code coverage and pricing information for the 2006 Annual and the 2005 October and July Quarterly updates, please refer to the upcoming Indiana Health Coverage Programs (IHCP) Provider bulletin at: www.indianamedicaid.com./ihcp/Publications/bulletin_results.asp

  The upcoming Provider bulletin will be available in January 2006, and will outline the codes and their respective coverage determinations.

  In addition, the annual and quarterly updates include some new alphanumeric and CPT codes that will require additional review by the IHCP. Providers will receive coverage and pricing determinations for these codes in a separate publication, after the review is completed.
- In a recent publication, EDS assigned the same IHCP Provider bulletin number, *BT200529*, to two different bulletins. The first bulletin, *BT200529*, dated December 1, 2005, is called "Changes in the Preferred Drug List." The second bulletin was incorrectly assigned BT200529 as well. This second bulletin, dated December 12, 2005, is called "Effective End Date of Current HoosierRx Program Structure and Start of State Pharmaceutical Assistance Program – HoosierRx - January 2006." Due to this situation, the first bulletin published December 1, 2005, titled "Changes in the Preferred Drug List," will be referred to as *BT200529**A***. Therefore, the second bulletin, published December 12, 2005, titled "Effective End Date of Current HoosierRx Program Structure and Start of State Pharmaceutical Assistance Program – HoosierRx - January 2006," will be referred to as *BT200529**B***.
- The Centers for Medicare and Medicaid Services (CMS) is consolidating the Medicare crossover process under a new Coordination of Benefits Agreement (COBA) initiative. In this initiative, CMS is contracting with one national Coordination of Benefits Contractor (COBC) to handle all crossover processing. The IHCP begins working with the COBC first quarter of 2006. The COBC will consolidate adjudication data from each of the Medicare intermediaries and send one transmittal of crossover adjudicated claims to the IHCP. Crossovers should continue to process as they do now, but because the interface is changing, providers need to monitor their crossover claims to ensure the process is working as expected.
- Please note the appropriate billing guidelines when submitting medical claims with modifier 50, *bilateral procedure*, on the claim detail. The Indiana*AIM* system calculates the payment for the procedure code billed with modifier 50 at 150 percent of the billed charge or the rate on file.

  If the Current Procedural Terminology (CPT®) code description specifies the procedure as bilateral, modifier 50 should **not** be used on the claim detail. The units billed should be reflected as one (1) in field 24G of the claim for those CPT® code descriptions for bilateral procedures. If the CPT® code description does not specify the procedure as bilateral, then modifier 50 should be used on the claim detail and the units billed should continue to be reflected as one (1). Providers submitting a claim with a bilateral procedure and multiple units should maintain supporting documentation in the member's medical record. Payment of claims will be monitored on a post-payment review basis.
- This article provides clarification on information published in the IHCP Provider bulletin *BT200511* dated June 1, 2005, about "Denied Service Lines on Crossover Claims." **Effective December 29, 2005**, the manner in which Medicare PART B crossover claims (Medical or Outpatient) are processed in the Indiana*AIM* system will be modified. When these claims are received in the 837 COB format, the Medicare denied service lines will post as denied service lines by the IHCP. This will eliminate the need for providers to adjust the claim.

  This change should expedite payment for Medicare-denied details. Currently the system will not allow payment of details that may have been denied by Medicare unless the provider first submits an adjustment to "reverse" the denied details.

Effective with this change, providers may submit a "Medicaid-only" claim to receive payment for denied details, without first completing an adjustment.

Providers may use the Web interChange to resubmit a claim previously received electronically from Medicare for consideration of the Medicare-paid service lines. However, the provider must delete the denied service lines from the claim. If the detail(s) is not removed from the claim and a provider submits a detail that reflects a zero amount in the coinsurance, deductible, psychiatric deductible, blood deductible, and Medicare-paid amounts, providers will receive an error message that states, "Detail is considered a Medicare-denied detail and should not be included on the claim. Please add crossover information or delete the detail."

To receive payment, providers must resubmit the Medicare Part B (Medical or Outpatient) denied detail(s) as a Medicaid fee-for-service claim. The Medicare Remittance Notice (MRN) must be submitted as an attachment to the claim for verification that the service(s) was denied by Medicare.

- This article informs IHCP providers of updates to the type of bill (TOB) codes that may be submitted to the IHCP program. **Effective December 29, 2005**, the IHCP is compliant with the UB92 editor TOB code set. However, not all codes are covered by the IHCP. If a claim with a valid TOB is submitted via Web interChange or an 837I transaction, but the TOB is not covered by the IHCP program, the claim will be adjudicated and denied with edit 594, *TOB is not covered by the IHCP*. If a claim is submitted via Web interChange with an invalid TOB, the provider will receive an error message that states, "Type of bill is not valid for this claim type." If a claim with an invalid TOB is submitted via the 837I transaction, the claim file will be rejected with error code 272, *invalid TOB.* This information will be reported to the provider or vendor on the Biller Summary Report (BSR). For a complete listing of error codes that are reported on a provider or vendor BSR and the complete listing of TOB codes, access the following links.

  Link for the listing of valid Type of Bill code set:

  http://www.indianamedicaid.com/ihcp/Forms/Type_of_Bill_Table.pdf

  Link for IHCP EDI reports & acknowledgements:
  http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/EDI_Reports.pdf

- The IHCP Web site now includes Ambulatory Surgical Center (ASC) assignment codes and pricing. The ASC assignment codes classify CPT® and Healthcare Common Procedure Coding System (HCPCS) codes to a payment group based on an estimate of the facility costs associated with performing the procedures. Providers may access this information on the IHCP Web site at www.indianamedicaid.com under *Fee Schedule*. The ASC listing contains assignment codes, effective dates, and pricing. Additionally, assignment codes relating to specific CPT® and HCPCS codes are available on the IHCP Web site at www.indianamedicaid.com under *Fee Schedule* using the procedure code or description search feature.

To All Anesthesia Providers:

- For the time period of October 15, 2003, through August 31, 2005, medical and Medicare Part B medical claims submitted for anesthesia services and billed with modifiers *QK, Medical direction of two, three, or four concurrent anesthesia service,* or *QX, CRNA service,* were inappropriately denied for edit *4014, no pricing segment on file.* Beginning the week of December 13, 2005, these claims were voided and reprocessed and began appearing on providers' remittance advice (RA) statements. The issue relating to adjudicated claims posting edit 4014 that had created underpayments has been corrected.

To All Hospice Providers:

- The IHCP completed a nursing home retro-rate adjustment for the nursing facility quality assessment fee. The IHCP began extracting the hospice claim information for this adjustment in October 2005. Claims were adjusted and appeared on November 8, 2005, Remittance Advices (RAs). Hospice providers can identify that the claims adjustments were a result of the nursing facility quality assessment by the internal control number (ICN) on their RA. These ICNs begin with the number 55 and have a Julian date between 304 and 306.

  For questions about the reimbursement process for hospice room and board adjustments that resulted from the nursing facility quality assessment, contact Michelle Stein-Ordonez at the OMPP at (317) 233-1956 or Karie Millard at Myers and Stauffer at (317) 846-9521.

To All Pharmacies and Prescribing Providers:

- The following is a correction to the State MAC rate information published in IHCP provider banner *BR200550*, dated December 13, 2005:

  Effective **January 27, 2006,** the following drug groups will be **added** to the State Maximum Allowable Cost (State MAC) for legend drugs rate list:

  Table 1 – State MAC Rate
  Effective January 27, 2006

Drug Name	State MAC Rate
ALBUTEROL 5 MG/ML SOLUTION	0.13935

  Direct any questions regarding the State MAC for legend drugs to the Myers and Stauffer pharmacy unit at (317) 816-4136 or (800) 591-1183, or email at pharmacy@mslc.com.

- Effective January 1, 2006, the CMS is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.

  The IHCP Web site now includes a section titled Medicare Prescription Drug Coverage. Providers should visit this section periodically at http://www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp for the latest information.

  For more information about the Medicare prescription drug benefit, visit the CMS Web site at http://www.cms.gov/medicarereform/.