B A N N E R P A G E

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All Providers

System Maintenance Announcement

EDS will perform system maintenance on Sunday, April 9, 2006, from 7 p.m. until 11:59 p.m., Eastern Daylight Time (EDT). The following systems will be unavailable during that time:

- Automated Voice Response (AVR)
- Batch electronic claim submission
- Omni eligibility system
- Point of Service (POS) pharmacy claim submission
- Web interChange

Make sure the appropriate business offices and software vendors are notified of this scheduled downtime.

Questions about this system maintenance announcement should be addressed to the EDS EDI Solutions Help Desk at (317) 488-5160, Indianapolis local area, or 1-877-877-5182.

COBA Update

Effective in March 2006, the Centers for Medicare & Medicaid Services (CMS) will consolidate the Medicare claims crossover process by means of the Coordination of Benefit Agreement (COBA). CMS has chosen a single entity, the Coordination of Benefits Contractor (COBC), to process the crossover claims. Providers will notice the results of the consolidation by the second week of April 2006. The COBC will cross over HIPAA-compliant claims. Crossover denied details will cross over indicating denied status. A new edit has been created, *0592 – Medicare denied detail*. This eliminates the need for providers to adjust the claim.

The COBC has provided Indiana Health Coverage Programs (IHCP) with a list of Medicare contractors that can provide claims adjudication and crossover through their processing systems. A list of these contractors will be available on the IHCP Web site at http://www.indiamedicaid.com beginning April 4, 2006.

The 835 Electronic Remittance Transaction

Beginning April 1, 2006 the 835, Electronic Remittance transaction will return a unique control number for each transaction, regardless of payment. Prior to April 1, 2006, the TRN02, Check/electronic funds transfer (EFT) Trace Number contained the text, *NO PAYMENT*, and a date and time stamp that was specific to the minute. If a trading partner had multiple claims with $0 payment reported on the 835, the TRN02 values would be identical. Per the *National Electronic Data Interchange Transaction Set Implementation Guide: Health Care Claim Payment/Advice: 835: ASC X12N 835 (004010X091)* and *(004010X091A1) Addenda*© TRN02 field description, "This number must be unique within the sender/receiver relationship."

To correct this issue, the IHCP will send the Transaction Set Control Number also found in the ST02 segment instead of a time stamp in TRN02. The IHCP creates a unique control number for each transaction sent to a trading partner, so duplicate TRN02 values should no longer be created. The full TRN02 value for a $0 payment 835 will be, *NO PAYMENT-YYYYMMDDXXXXXXXXX*, where YYYYMMDD is the date the transaction is created and XXXXXXXXX is the Transaction Set Control Number.

Direct questions about this article to the Electronic Solutions Help Desk at (317) 488-5160, in the Indianapolis local area, or 1-877-877-5182, or by e-mail at INXIXElectronicSolution@eds.com.

Type of Bill Code Set Update

This article provides clarification about updates to the Type of Bill (TOB) code set published in the IHCP banner page *BR200601* dated January 3, 2006.

The IHCP updated the *Type of Bill Information* document in Web interChange to include all TOB codes that are available for use per the *UB-92 Editor*. The IHCP does not cover all codes. The new document lists the *Type of Bill Code*, *Description*, *Processing Decision* indicator (*Accept*, *Deny*) and *Claim Type*.

This article is to notify IHCP providers of a change to the IHCP program for TOB 731 and the 22X series.

- TOB code 731is now valid and covered by the IHCP for crossover C and outpatient claim types.
- TOB codes for the 22X series are now valid and covered for crossover A.
- Inpatient claim type is valid, however, it is not a covered TOB for the IHCP.

As stated in *BR200601*,

- If a provider submits a claim with a valid TOB using Web interChange or an 837I transaction, but the TOB is non-covered by the IHCP, the claim will be adjudicated and denied with *Edit 594 – Type of Bill non-covered by IHCP*.
- If a provider submits a claim using 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 the provider submits a claim with an invalid TOB using the 837I transaction, the claim file will be rejected with error code *272 – Invalid TOB.* This information is reported to the provider or vendor on the *Biller Summary Report* (BSR).

The updated TOB document is available from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Forms/Type_of_Bill_Table.pdf.

Medicare Denied Details for Crossover Claims Processing

This article provides clarification to information published in the IHCP banner page *BR200551* dated December 20, 2005, about "Denied Service Lines on Crossover Claims." Effective March 21, 2006, changes have been made in the way Medicare Part B crossover claims (medical or outpatient) are processed in Indiana*AIM*.

Web interChange has been modified to allow denied service lines to be entered for crossover claims. These details will process and deny with *Edit 593 – Medicare denied details*.

Crossover A Claims Submitted through Web interChange: Coordination of benefits (COB) adjustment information can be reported at the header and detail, but must be present at the header for claims adjudication. If detail COB adjustment information is present it is ignored.

Crossover B (Medical) Claims Submitted through Web interChange: COB adjustment information must be reported at the detail level. If COB adjustment information is present at the header and detail, then the sum of the detail must be equal to the header. If they are not equal, the user receives an error stating, "The header and detail crossover amounts are not equal."

Note: Provider specialties 260, 261, and 264 continue to report COB adjustment information at the header level as the IHCP has excluded this specialty from the modification.

Crossover C (Outpatient) Claims Submitted through Web interChange: COB adjustment information may be reported at the header or detail level. If COB adjustment information is present at the header and detail, then the sum of the detail must be equal to the header. If they are not equal, the user receives an error stating, "The header and detail crossover amounts are not equal."

837I Crossover A Claims Submitted through EDI: COB adjustment information can be reported at the header and detail level but must be present at the header for claims adjudication. If header COB adjustment information is not present, then *Biller Summary Report* (BSR) 280 is sent back to the provider stating, "Crossover A claims must contain crossover amounts (Medicare paid, deductible, coinsurance, and blood deductible amounts) at the header level." If header and COB adjustment information **do not** balance, the claim is still processed.

837I Crossover C Claims Submitted through EDI: COB adjustment information can be reported at the header and detail but must be present at the detail for claims adjudication. If header and detail COB adjustment information is present, then they must balance. If they do not balance, then BSR 277 is sent back to the provider stating, "Crossover adjustment amounts (deductible, coinsurance, and blood deductible amounts) at the detail do not balance with the header crossover adjustment amounts."

837P Crossover B Claims Submitted through EDI: COB adjustment information can be reported at the header and detail level. If COB adjustment information is present at the header and detail level, then the sum of the detail must be

equal to the header. If they do not balance, then BSR 277 is sent back to the provider stating, "Crossover adjustment amounts (deductible, coinsurance, and blood deductible amounts) at the detail do not balance with the header crossover adjustment amounts."

Available Resources: Complete information regarding EDI reports is contained in the *Companion Guide: Electronic Data Interchange Reports and Acknowledgements* located on the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/EDI_Reports.pdf.

More information regarding COBs can be found by selecting the **FAQ** menu option on the Web interChange site at https://interchange.indianamedicaid.com/Administrative/logon.asp.

2006 January Quarterly HCPCS Codes Update

The Centers for Medicare & Medicaid Services (CMS) released the 2006 January Quarterly Healthcare Common Procedure Coding System (HCPCS) codes update. The update includes HCPCS C codes used for services paid by the Medicare Outpatient Prospective Payment System, and HCPCS G codes used to report Medicare-approved demonstration project services. These codes are not used by the Indiana Health Coverage Programs (IHCP), and are noncovered in Indiana*AIM*.

IHCP E-Mail Notifications Program

On January 17, 2006, EDS and the IHCP launched the IHCP E-Mail Notifications program. This program automatically issues e-mails to subscribers when IHCP publications and announcements are posted to the IHCP Web site.

This service is **free** and available to both providers and non-providers. It is possible to have multiple subscriptions to provide notifications at office, home, or to other e-mail addresses for associates and staff. To subscribe to the service, visit the IHCP Web site at http://www.indianamedicaid.com.

On the *IHCP E-mail Notifications* page, click the **Open New Account** button, complete the profile information, and select the publications for e-mail notifications. You will receive a Subscription Request e-mail with instructions and a link to activate your subscription. You must follow the link in the e-mail to activate your registration. Once your subscription is activated you will receive a Welcome! e-mail to verify the activation. You may subscribe or unsubscribe at any time. Each notification e-mail contains a link for updating your subscription profile or unsubscribing to the service.

Publications are posted to the Web site on Tuesdays and Thursdays of each week. For a period of time *both* e-mail notifications and paper copies of the publications will be provided.

Pharmacies and Prescribing Providers

State Maximum Allowable Cost Rate Update

Effective April 28, 2006, the drug groups shown in Table 1 will be added to the State Maximum Allowable Cost (State MAC) for legend drugs rate list.

Table 1 – Additions to State Maximum Allowable Cost for Legend Drugs Rate List, Effective April 28, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMPICILLIN-SULBACTAM 3 GM VL	1.50504	POLYETHYLENE GLYCOL 3350 POWDER	0.07060
ANAGRELIDE HCL 0.5 MG CAPSULE	0.37520	PROMETHAZINE 50 MG TABLET	0.63040
D5-1/2NS/KCL 10 MEQ/L IV SOL	0.00377	QUINAPRIL/HCTZ 20/12.5 TABLET	1.01950

Effective March 14, 2006, State MAC rates for the drugs shown in Table 2 will be increased.

Table 2 – Increases to State Maximum Allowable Cost for Legend Drugs Rates, Effective March 14, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMOXICILLIN 500 MG CAPSULE	0.05694	IBUPROFEN 800 MG TABLET	0.04907
HYDROCODONE/APAP SOLUTION	0.03072		

Effective March 31, 2006, State MAC rates for drugs shown in Table 3 will be decreased.

Table 3 – Decreases to State Maximum Allowable Cost for Legend Drugs Rates, Effective March 31, 2006

Drug Name	State MAC Rate
METOPROLOL 50 MG TABLET	0.03672

Effective April 28, 2006, State MAC rates for the drugs shown in Table 4 will be decreased.

Table 4 – Decreases to State Maximum Allowable Cost for Legend Drugs Rates, Effective April 28, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMANTADINE 100 MG CAPSULE	0.28926	IPRATROPIUM BR 0.02% SOLN	0.05748
BRIMONIDINE 0.2% EYE DROP	3.02340	PERMETHRIN 5% CREAM	0.14450
CIPROFLOXACIN HCL 750 MG TAB	0.19353	PROCHLORPERAZINE 25 MG SUPP	1.17650
CYPROHEPTADINE 4 MG TABLET	0.13632	RANITIDINE 150 MG TABLET	0.04265
DIGOXIN 125 MCG TABLET	0.10488	SULFAMETHOXAZOLE/TMP DS TAB	0.08468
ECONAZOLE NITRATE 1% CREAM	0.33440	SULINDAC 200 MG TABLET	0.23447
GABAPENTIN 300 MG CAPSULE	0.34480	TRAMADOL HCL-ACETAMINOPHEN TAB	0.57873
GABAPENTIN 600 MG TABLET	0.96261	TRIAMCINOLONE 0.1% CREAM	0.04195
GABAPENTIN 800 MG TABLET	1.14227	TRIAMTERENE/HCTZ 37.5/25 CP	0.05411
HYDROCHLOROTHIAZIDE 25 MG TB	0.02316	VERAPAMIL 120 MG TABLET	0.07650
HYDROCODONE/APAP 10/500 TAB	0.15317	VERAPAMIL 120 MG TABLET SA	0.47612
OMEPRAZOLE 20 MG CAPSULE DR	0.97695		

Direct any questions regarding the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit at (317) 816-4136, Indianapolis local area, or (800) 591-1183, or e-mail at pharmacy@mslc.com.

Accessing Program Information for Medicaid Drug Rebate and Federal Upper Limits

Providers may now verify a manufacturer's participation in the CMS federal Medicaid Drug Rebate Program by visiting http://www.indianapbm.com/, and selecting **Drug Rebate Labelers** from the *Pharmacy Services* menu. In addition, providers can access CMS Web site for the latest rates and information for the Federal Upper Limits (FUL) Program by selecting **Federal Upper Limits (FUL) Program (FMAC)** from the *Pharmacy Services* menu, or by visiting http://www.cms.hhs.gov/FederalUpperLimits/. E-mail your questions to PDL@fssa.state.in.us.

Medicare Prescription Drug Coverage – Medicare Part D

Effective January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) implemented the new Medicare prescription drug coverage, also known as Medicare Part D. This coverage is a new benefit to help Medicare members pay for prescription drugs.

The IHCP Web site 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.hhs.gov/PrescriptionDrugCovGenIn/.