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All Providers

Presumptive Eligibility: Selecting a Primary Medical Provider and a Managed Care Organization

When a qualified provider (QP) facilitates the completion of the Presumptive Eligibility (PE) Application for Pregnant Women, the QP must provide a telephone for the applicant to contact the enrollment broker, MAXIMUS, to choose her primary medical provider (PMP) and managed care organization (MCO). The applicant must make these selections the same day she applies for PE. The QP cannot influence the selection process in any way. MAXIMUS will explain the selection process and identify women who are exempt from choosing PMPs and MCOs.

Once the selection of the PMP and MCO is made, the member has the right to change her selection at any time during her PE period by contacting MAXIMUS. The QP who performs the PE enrollment process will be paid for the services provided the day of the application, even if the member chooses a different doctor as her PMP.

Presumptive Eligibility Process

Qualified providers (QPs) must ensure that all the following steps are completed the same day a presumptive eligibility (PE) applicant is in the provider's office:

1. Verify pregnancy via a professionally administered pregnancy test.
2. Verify eligibility using Web interChange.
3. Access the PE Member Application via Web interChange.
4. Complete and submit the PE Member Application.
5. Give the PE applicant the PE determination letter.
6. If the PE applicant is approved for PE, she must contact the enrollment broker to choose her primary medical provider (PMP) and managed care organization (MCO). The PE applicant's selections must be written on the PE determination letter.
7. The QP must have the PE applicant verify all the information on the Hoosier Healthwise Application, sign the application, and fax it to the appropriate Division of Family Resources (DFR) office or the Documentation Center for Modernized Counties. QPs should also include a statement of pregnancy.

All the above steps must be completed on the same day the member is in the provider's office. Failure to complete the PE application and have the member contact the enrollment broker will result in termination of PE for the member and no reimbursement for the services provided by the QP.

Mental Health Quality Advisory Committee Utilization Edits

On June 19, 2007, the Mental Health Quality Advisory Committee's (MHQAC's) recommended utilization edits for mental health medications were implemented (refer to provider bulletin BT200709, dated May 3, 2007). The utilization edits are reviewed quarterly, and the additions in Table 1 will be made **August 28, 2009**.

Table 1 – First-quarter 2009 MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
Venlafaxine HCl 37.5mg tab OSM 24 Oral	1/day
Venlafaxine HCl 75mg tab OSM 24 Oral	2/day

Name of Medication and Strength	Utilization Edit
Venlafaxine HCl 150mg tab OSM 24 Oral	1/day
Venlafaxine HCl 225 mg tab OSM 24 Oral	1/day

The following additions and updates will be made **September 11, 2009**.

Table 2 – Second-quarter 2009 MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
Bupropion HBR 348mg tab SR 24H oral	1/day
Bupropion HBR 522mg tab SR 24H oral	1/day
Alprazolam 0.25mg ODT	4/day
Alprazolam 0.5mg ODT	4/day
Alprazolam 1mg ODT	4/day
Alprazolam 2mg ODT	4/day
Seroquel XR 150mg tablet	1/day
Cymbalta 60mg capsule	2/day
Lexapro 20mg tablet	2/day
Venlafaxine XR 150mg capsule	2/day

Claims for "Returned-to-Stock" Prescriptions
Claims that have been billed to and paid by the program for prescriptions that have been filled but not received by the member or the member's representative must be reversed within 15 calendar days of the date of service. The date of service is considered "day 1." This policy is effective September 11, 2009.

Returned Medications
State laws IC 25-26-13-25(h) and (i); 856 IAC 1-21-1 allow for the return of medications from long-term care (LTC) facilities under certain circumstances to the pharmacy that dispensed the medications.

> Note: Medications returned to the dispensing pharmacy that are put back in stock for redispensing must be credited to the program within 30 days of being returned to the pharmacy.

To credit the program, providers must submit a credit request for the amount of the returned medication, less any applicable dispensing fee. This amount is applied against future payments. The credited amount is posted to the provider Remittance Advice, and totals on the Provider 1099 Summary Report are adjusted. "Chapter 11: Paid Claim Adjustment Procedures" in the IHCP Provider Manual contains specific procedures for crediting the program for returned medications.

The Indiana Health Coverage Programs (IHCP) requires that both the LTC pharmacy and LTC facilities document the medications being returned and credited to the program. Both providers are also required to document any medications being destroyed. Providers should have a log outlining the prescription number, name of medication, date the medication was returned and credited or destroyed, quantity returned and credited or quantity destroyed, and, if the medication was destroyed, to whom it was returned for destruction. The pharmacy auditing contractor, Prudent Rx, will verify compliance with these requirements. LTC pharmacies and LTC facilities found to be noncompliant will be referred to the Indiana Medicaid Fraud Control Unit (IMFCU).

Coverage of Image-guided Robotic Linear Accelerator Stereotactic Radiosurgery – Healthcare Common Procedure Coding System Codes G0339 and G0340

Effective December 1, 2008, the Indiana Health Coverage Programs (IHCP) began providing coverage of image-guided robotic linear accelerator-based stereotactic radiosurgery (SRS). This service is billable through the Healthcare Common Procedure Coding System (HCPCS) Code G0339 – Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment; and through code G0340 – Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes

and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment. Providers that received denials for dates of services on or after December 1, 2008, with error code 520 – Invalid revenue code/procedure code combination – for the HCPCS codes above may resubmit those claims.

UB-04 Paper Claim Form Locator 17 – Patient Status Codes

Table 3 includes the current patient status codes that are valid for UB-04 paper claim forms, form locator 17, as well as upcoming changes. Providers are reminded to refer to the most current edition of the Uniform Billing Editor for proper use of patient status codes.

Note: Patient status code changes are in bold type in Table 3.

Table 3 – UB-04 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
17*	**STATUS** – Enter the code indicating the member discharge status as of the ending service date of the period covered on this bill. **Required for inpatient and long-term care (LTC).**
Patient Status Codes	
Code	**Description**
01	Discharged to home or self-care, routine discharge
02	Discharged or transferred to another short-term general hospital for inpatient care
03	Discharged or transferred to skilled nursing facility (SNF)
04	Discharged or transferred to an intermediate care facility (ICF)
05	**Discharged or transferred to a designated cancer center or children's hospital. New description effective September 30, 2009, for claims with discharge dates on or after April 1, 2008.**
06	Discharged or transferred to home under care of organized home health services organization
07	Left against medical advice or discontinued care
08	**Discharged or transferred to home under care of a home intravenous provider. Patient status code 08 will be changed from active to inactive effective for claims received on or after September 30, 2009, for claims with discharge dates on or after October 1, 2005.**
20	Expired
30	Still a patient
43	Discharged or transferred to a federal healthcare facility
50	Discharged to hospice – home
51	Discharged to hospice – medical facility
61	Discharged or transferred within this institution to hospital-based Medicare swing bed
62	Discharged or transferred to another rehabilitation facility including discharge planning units of hospital
63	**Discharged or transferred to a long-term care hospital (long-term care facility changed to long-term care hospital), effective for date of receipt September 30, 2009**
64	Discharged or transferred to a nursing facility – Medicaid-certified but not Medicare-certified
65	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (effective April 1, 2004)
66	Discharged or transferred to a critical access hospital (effective January 1, 2006)

Code	Description
70	**Discharged or transferred to another type of healthcare institution not defined elsewhere in code list. Effective September 30, 2009, for claims with discharge dates on or after April 1, 2008. (This was previously the 05 description.)**

Patient Transfers
Special payment policies apply to transfer cases paid using the diagnosis-related group (DRG) methodology. The receiving hospital, or transferee hospital, is reimbursed according to the DRG or level-of-care (LOC) methodology, whichever is applicable. Transferring hospitals are reimbursed a DRG-prorated daily rate for each day, not to exceed the full DRG amount. The IHCP calculates the DRG daily rate by dividing the DRG rate by the average length of stay. The full payment to the transferring hospital is the sum of the DRG daily rate, the capital per diem rate (up to the DRG average length of stay), and the medical education per diem rate (up to the DRG average length of stay). Transferring hospitals are eligible for outlier payments.

To ensure accurate reimbursement, the appropriate discharge status code of 02, 05, 62, 63, 65, 66, and 70 must be placed in the UB-04 form locator 17 on the claim form. (See Table 3 for effective dates.)

Action Required to Access Remittance Advices after September 1, 2009

The implementation date for paperless provider communications – September 1, 2009 – is quickly approaching. Be sure to sign up for Web interChange today, so you can access your electronic Remittance Advices (RAs). Remember – it takes seven to 10 business days for the Web interChange approval process.

As of September 1, 2009, the IHCP will no longer print and mail provider RAs generated by EDS, banner pages, bulletins, or newsletters (including the Drug Utilization Review Board newsletters). These publications will only be available online.

To keep informed of current communications and policy updates, providers must enroll in the IHCP's E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp. Providers who are already enrolled should verify that their e-mail addresses are correct.

Paper checks that are mailed with the current RAs will continue to be mailed after September 1, 2009, for providers not enrolled in electronic funds transfer (EFT).

Instructions for how to access RAs on Web interChange will be included in the August 2009 provider newsletter.

Claim Correction Forms
Currently, Claim Correction Forms (CCFs) are included with paper RAs. Effective September 1, 2009, the IHCP will no longer print CCFs. Providers can resubmit denied claims with corrections through the existing claims billing process.

For more information, see page 6 of the July provider newsletter NL200907 ("The IHCP Implements Paperless Provider Communications") and bulletin BT200912, "Implementation of Paperless Provider Communications," dated May 19, 2009.

Hospice Providers

Hospice Rate Update

IHCP Provider Bulletin BT200917, dated June 16, 2009, announced updates to hospice rates for claims with dates of service October 1, 2008, through September 30, 2009.

Hospice claims with revenue codes 651, 652, 655, and 656 that are affected by the revised rates were scheduled to be systematically mass adjusted and appear the week of July 20, 2009; they will now appear the week of August 4, 2009.

CMS-1500 Billing Providers

CMS-1500 Medical Paper Claim Submissions for Emergency Services

Effective February 1, 2009, EDS moved to a new scanning system for CMS-1500 paper claim forms. From February 1, 2009, to June 11, 2009, if the emergency indicator (form locator 24C) at the detail level of the claim was marked "Y" (yes) for emergency, the system defaulted the indicator to "N" (no). This may have caused inappropriate claim denials or payments.

For claims that completely denied, EDS requests that providers resubmit paper claim forms that were processed during this time period and that have an emergency indicator of "Y" in field 24 C. If the claim was partially paid or if a copay was inappropriately deducted, please submit a Paid Claim Adjustment form to EDS and state in Box 10, "Emergency Indicator Correction." This will help ensure that paid claim adjustments are processed as expected.

Note: This affected only paper claims; electronically submitted claims were not affected.

Provider Workshops

Addition!

The third-quarter provider workshops feature a session on Presumptive Eligibility for Pregnant Women and Notification of Pregnancy, two new programs that began July 1, 2009. The Presumptive Eligibility session runs from 2:40-4:45 p.m. This information did not appear on the paper registration form included in the July newsletter, NL200907. Providers are encouraged to register online instead of using the paper registration form. Workshop registration is available at http://www.indianamedicaid.com/ihcp/index.asp. Click on **Provider Services**; **Educational Opportunities**; **Workshop Registration**.

Third-quarter Workshops

The IHCP is offering quarterly provider workshops free of charge. Topics include Hoosier Healthwise open enrollment; Care Select; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); a managed care and Healthy Indiana Plan (HIP) roundtable; blood lead testing; and Presumptive Eligibility/Notification of Pregnancy. Workshop agendas, dates, registration deadlines, and locations are online at http://provider.indianamedicaid.com/general-provider-services/provider-education/workshop-registration.aspx. You may register online or by using the registration form printed in the IHCP provider newsletter. For more information about the workshops, please contact the workshop line at (317) 488-5072.

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