I M P O R T A N T I N F O R M A T I O N

B R 1 9 9 9 5 2 D E C E M B E R 2 8 , 1 9 9 9

To All Indiana Health Coverage Programs Optometrists, Ophthalmologists, and Opticians:

- Providers are advised to bill **one line item** with **two units** for V codes when billing two individual lenses of the **same** prescription. If the prescription for each lens is **different**, billing should be done on **two different line items** with **one unit** per line item billed for each lens using the appropriate V code.

  Providers previously billing with local Z codes only billed one line item with one unit because the description for the local Z codes stated per pair. However, V codes are billed per lens. The local Z codes were end dated on November 1, 1999, and can no longer be billed for dates of service later than October 31, 1999. Providers billing with V codes, effective November 1, 1999, are reimbursed per lens based on the appropriate code for lens type dispensed and the appropriate units billed. For example, one lens equals one unit.

  *Note: Please change the word Lenses in bulletin BT199916 (Changes for Billing Vision Services dated September 15, 1999) on page 7, in Table 1.1, under Category, to read **Lens**, Single Vision, Glass or Plastic.*

To All Indiana Health Coverage Programs Providers:

- The year 2000 (Y2K) will arrive shortly and the Indiana Health Coverage Programs (IHCP) are ready. The following describes important points to consider as the new year approaches:
  - The automated voice response (AVR), point of sale (POS), and electronic claims submittal (ECS) systems will be unavailable for approximately one hour, from Friday, December 31, 1999, at 11:30 p.m. to Saturday, January 1, 2000, at 12:30 a.m., as these systems are transitioned to the new year.
  - Electronic claims received by 4 p.m. on Thursday, December 30, 1999, will be processed in the December 30, 1999, weekly cycle. Claims received after that time will be processed the following week.
  - No claims submission formats have changed, so there is no need for providers to change the way they submit claims.
  - National Electronic Claims Submission (NECS) users will receive the upgraded version of this software within the next week. Please see the installation instructions for details on how and when to install this upgrade. For questions regarding this upgrade, please call the ECS Help Desk at (317) 488-5160 or (317) 488-5158.
  - Providers should develop contingency plans and ensure that all staff members are aware of these plans. IHCP outlined Y2K contingency plans for eligibility verification, provider payment, and prior authorization in bulletin BT199944, Year 2000 Readiness Update, dated December 15, 1999. IHCP encourages providers to maintain this information in the event of disruption.
  - Previous Y2K bulletins can be accessed through the Indiana Medicaid Web site at www.indianamedicaid.com on the Y2K page.
  - The Indiana Office of Medicaid Policy and Planning (OMPP) and EDS will observe holidays on Thursday, December 23, 1999, Friday, December 24, 1999, and Friday, December 31, 1999. AVR and POS will be operational even though the administrative offices will be closed during these days.

  No problems are anticipated, but if difficulties occur, please call EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To All Indiana Health Coverage Programs Mental Health Providers, Physicians, and Psychologists:

- As required by the House Enrolled Act (HEA) 1396, OMPP is amending the mental health services sections of the Covered Services Rule (*405 IAC 5-20 and 405 IAC 5-21*). The rule changes will include requirements of HEA 1396, as well as other changes. The promulgation process will not be completed by January 1, 2000. However, those changes that are mandated by the provisions of this act are effective for dates of service January 1, 2000, or after. These provisions are described below:
  - Reimbursement will become available for services provided by midlevel practitioners in an outpatient mental health facility when services are supervised by a health services provider in psychology (HSPP). Services rendered by midlevel practitioners must be billed under the provider number of the outpatient mental health clinic or facility. An HSPP may certify the diagnosis or supervise the plan of treatment.
  - The list of practitioners rendering outpatient, supervised mental health services, for which Medicaid will reimburse, is amended. The following have been added to the list of practitioners currently included in these sections of the rule: independent practice school psychologists and advanced practice nurses under *IC 25-23-1-1(b)(*3*)*, credentialed in pyschiatric or mental health nursing by the American Nurses Credentialing Center.
  - Services provided by mid-level practitioners must be billed using the supervising physician's number in Box 24K of the HFA 1500 form. The appropriate modifier must be used to ensure correct reimbursement as follows: social workers use AJ, psychologists use AH, nurses use AK, AL, AY, AV, or YK.

To All Indiana Health Coverage Programs Chiropractors:

The purpose of this banner message is to clarify the banner message that was sent with the remittance advice notice on December 7, 1999. There have been no changes to services that can be provided to traditional Medicaid or Hoosier Healthwise members by chiropractors. Members remain eligible for up to 50 treatment services per calendar year. In addition, members may receive five office visits, specifically codes 99201-99203, for new patients, in combination with codes 99211-99213 for established patients in a calendar year. New patient codes are limited to one per provider, per member, but total new and established visits for a member may not exceed five per calendar year.

Please note that Package C members of the Hoosier Healthwise Program are eligible for five office visits per calendar year as described above. They are also eligible for 50 treatments per calendar year, but since funding for this program is separate from Medicaid, after 14 treatments, prior authorization (PA) must be obtained by writing to: Health Care Excel, P.O. Box 531520, Indianapolis, IN 46253-1520. A PA form and directions for submitting PA requests can be found in the Indiana Health Coverage Programs Provider Manual (chapter 6) which may be found at www.indianamedicaid.com.

Currently, chiropractors can access the Eligibility Verification Systems (EVS), Automated Voice Response (AVR), National Electronic Claims Submission (NECS), and OMNI to obtain information regarding whether a member has exhausted the five visits. However, from January 10, 2000, through June 2000, this information will no longer be available on AVR, NECS, or OMNI. An analysis of claims billed by chiropractors for office visits indicated that if each chiropractor tracks office visits for each member, providers will be able to verify when the enrollee has reached the limit of five per calendar year. Eligibility information for all Medicaid and Hoosier Healthwise members will be available on all EVS effective January 10, 2000.