IMPORTANT INFORMATION

BR200027 JULY 4, 2000

To All Indiana Health Coverage Programs Providers

- Effective June 29, 2000, Medicaid Rehabilitation Option (MRO) services will only be reimbursed when billed on a HCFA-1500 claim form by a Community Mental Health Center (CMHC). Any MRO services not billed on a HCFA-1500 claim form by a CMHC will deny for edit 1040, *MRO services can only be billed on a HCFA-1500 by a CMHC*. If there are any questions, please contact EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278.
- Since March of 1999, outpatient claims have been denying for edit 4091, *add-on service was billed without a treatment room or stand-alone service*, when billing for add-on services. These claims should have denied only the detail containing the add-on service, not the entire claim. These claims will be reprocessed on July 3, 2000, and will appear on the July 11, 2000, remittance advice. As a reminder for outpatient claims, add-on services will only be reimbursed when billed on the same claim with a payable treatment room or stand-alone service. If there are any questions, please contact EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278.
- Indiana Health Coverage Programs (IHCP) covers observation stays in acute care hospitals and freestanding psychiatric (including chemical dependency) hospitals. IHCP members may qualify for observation status under the following circumstances:
    1. The criteria for inpatient admission have not been met; and
    2. The treating physician or mental health provider has determined that allowing the member to leave the facility would likely put the member at serious risk.

  The observation period must last no more than three days (72 hours). If the member meets the criteria for inpatient admission prior to the end of the observation period, the member's status may be changed to inpatient at that time. If there are any questions, please contact EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278.

To All Indiana Health Coverage Programs Chiropractic Providers

- This article is to clarify information communicated in Bulletin *BT200019*, dated June 16, 2000, about chiropractic services. Explanation of Benefit (EOB) code 6122, *Chiropractic therapeutic physical medicine treatments 15 through 50 require prior authorization*, is specific to members enrolled in the Hoosier Healthwise Package C program. There have been no changes to the coverage or limitations for chiropractic services for members enrolled in the Hoosier Healthwise Package A, B, or traditional Medicaid programs. When verifying eligibility, the provider will receive the benefit limitation information relative to the program the member is enrolled in on the date inquired about. For example, if a provider is verifying eligibility for a member of the Hoosier Healthwise Package C program, the provider will receive benefit information for services provided during the members Package C eligibility segment. It is important to note that different medical programs can have different service limitations. Separate audits are utilized when service limitations (number of a particular service allowed per time period) differ between eligibility programs. EVS will report the correct one back, based on the recipient's eligibility as of the date inquired upon. If there are

any questions, please contact EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278.

To All Indiana Health Coverage Programs Transportation Providers

- Effective June 29, 2000, all transportation base rate and related services must be submitted on the same claim form. Failure to submit related transportation services with a paid base rate will result in claim denial for the related services. If a claim is submitted and the base rate is paid but the related transportation service is denied, an adjustment will need to be submitted for both the base rate and the related service in order for payment to be made for the related service. The Internal Control Number (ICN) for the paid base rate must be the ICN denoted on the adjustment form. If the base rate for transportation has been paid by Medicare, providers must submit the Explanation of Medicare Benefits (EOMB) with the claim for mileage to Medicaid. Claims with an attachment (region 11) will suspend for review of the EOMB for the base rate so that the mileage can be paid. If there are any questions, please contact EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278.

To All Indiana Health Coverage Programs Dental Providers

- Comprehensive or detailed and extensive oral evaluations are limited to one per member, per provider, per lifetime. Effective June 29, 2000, claims submitted by a provider for a member who has not received payment for either D0150 or D0160 will now bypass audit 6226, *comprehensive/extensive oral examination limited to one/lifetime.* This limitation audit will fail when more than one comprehensive or detailed and extensive oral evaluation is billed for any member by the same provider. If there are any questions, please contact EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278.