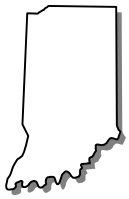

IMPORTANT INFORMATION

BR200147 NOVEMBER 20, 2001

To All Providers:

- The Indiana Health Coverage Programs (IHCP) is planning now for the changes required by the federal *Health Insurance Portability and Accountability Act (HIPAA)*. Major changes in processing electronic transactions and paper claims that must be made by October 2002 are included. Changes to better protect patient privacy must be in place by April 2003. Please see the *HIPAA section* of the IHCP Web site, www.indianamedicaid.com, for more information. Address questions not covered on the Web site in writing to the following address:

  EDS HIPAA Correspondence
  P.O. Box 7263
  Indianapolis, IN 46207-7263

- This notifies all providers of a change in the amount charged for the *IHCP Provider Manual* and copies of Remittance Advices (RAs). Effective December 1, 2001, the amount charged for duplicate copies of RAs greater than one year from date of request will be reduced from $0.15 per page to $0.10 per page. Duplicate copies of RAs can be ordered by writing to the following address:

  Provider Written Correspondence
  P.O. Box 7263
  Indianapolis, IN 46207-7263
  (317) 655-3240 in Indianapolis Area
  1-800-577-1278 outside Indianapolis

  The cost for paper copies of the *ICHP Provider Manual* will increase to $121.60. The *IHCP Provider Manual* can be downloaded free from the Web site at www.indianamedicaid.com or can be ordered in CD-ROM format by writing to EDS Provider Enrollment at the above address or by calling (317) 655-3240 or 1-800-577-1278. The CD-ROM is free of charge to IHCP-enrolled providers. A $20 fee will be assessed to nonproviders requesting the CD-ROM version of the manual.

- Provider bulletin *BT200130* recently revised the codes to be used for incontinence supplies. The new codes, *S8400 – Incontinent pants, S8402 – Diapers, S8405 – Incontinent liners, A4554 – Disposable underpads,* and *A4335 – Incontinence supply; miscellaneous,* were omitted from the Medicare/Third Party Liability bypass audit. These codes were added to the bypass audit on September 28, 2001. Providers must resubmit claims previously denied with *EOB 2502* or *2503*. Please remember an incontinence diagnosis must be documented on the submitted HCFA-1500 claim form.

- Note the following clarification to bulletin *BT200143*. Providers whose claims crossover appropriately from the Medicare intermediary to EDS are not required to submit the *Medicare/IHCP Provider Number Cross Reference Data Sheet* form. To determine if your claims are crossing over appropriately from the intermediary, please review your remittance advice for crossovers with ICNs beginning with 20. Appropriate crossovers reflect the correct service location and rendering provider information.

- EDS previously reported that AdminaStar would recreate Medicare Part B tape for the week of July 14, 2001. EDS and AdminaStar determined this tape cannot be recreated. Providers must submit the crossover claims on paper with the appropriate Medicare Explanation of Benefit (EOB) attached. The crossover claims must be submitted to the following address:

  EDS – Indiana Health Coverage Program
  P. O. Box 7267
  Indianapolis, IN 46207-7267

- Effective October 1, 2001, the new *ICD-9-CM* diagnosis and *ICD-9-CM* procedure codes are in Indiana*AIM*. The new codes should now be used for all HCFA-1500 claims. However, the system processing components for pricing and editing is **not yet** complete for these new codes. Therefore, **inpatient** claims submitted with the new codes will deny for explanation of benefit (EOB) code *4116 – Diagnosis code is not valid for DRG pricing*. Upon completion of the component linkage EDS will systematically reprocess all **inpatient** claims, and the reprocess date will be published in a future banner page article. Direct any questions to the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis area or outside Indianapolis at 1-800-577-1278.

- **All providers are asked to forward the updated information to the bulletin recipients in each organization**. The October 25, 2001, Bulletin *BT200140*, was mailed the week ending October 28, 2001. The bulletin described the plan for current Prime*Step* Hoosier Healthwise members, in specific counties, to transition from primary care case management (PCCM) to enrollment in a

local managed care organization (MCO) in the risk-based managed care (RBMC) delivery system. Minor revisions to the information published in the bulletin are available in a revised version of the bulletin *BT200140*, available on the Web at www.indianamedicaid.com. Both the original and the revised bulletin are available. Please refer to the Web site's revised release for the most current information about mandatory MCO enrollment in specific Indiana counties.

To All Prescribing Practitioners and Pharmacy Providers:

NOTE: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

- Effective January 7, 2002, the prior authorization program for drugs, The Indiana Rational Drug Program, will be implemented. The program will cover the following two drugs and three drug classes: Stadol-NS®, Ultram® (Tramadol), peptic ulcer disease drugs, nonsteroidal anti-inflammatory drugs (NSAIDS, including Cox-2 inhibitors), and growth hormones. A bulletin will be published outlining policy and procedures prior to the scheduled implementation date. All prescriptions for IHCP members will be subject to this policy. Providers can access program criteria approved by the Drug Utilization and Review (DUR) Board through the *What's New – Noteworthy Clinical Information* link on the DUR Board page of the IHCP Web site at www.indianamedicaid.com. The link to the DUR Board Web page is located on the home page, under the *Provider Services* drop-down menu.
- This notifies providers that pharmacy claims processed with the calculated Medicaid allowable of AWP minus 13 percent, plus $3 dispensing fee will be adjusted and appear on the remittance advice dated November 27, 2001. The adjustment will reflect the calculated Medicaid allowable rate of AWP minus 10 percent, plus $4 dispensing fee.

To All Physicians and Clinics:

- This information clarifies appropriate billing procedures for antepartum visits. Antepartum care rendered to pregnant members should be billed separately from the delivery and postpartum visits. Bill each antepartum visit separately using CPT procedure codes 59425 or 59462. Submit visits one through six with the procedure code 59425 at each visit. Bill the seventh and all subsequent visits with procedure code 59426 at each visit.

  To identify antepartum visits in each trimester, one of the following modifiers must be billed in conjunction with procedure code 59425 or 59426 with each specific date of service. **The chart below shows the appropriate trimester modifier and its description.**

Table 1.1 – Modifiers-Antepartum Visits, CPT Procedure Codes 59425, 59426

Modifiers	Description
Z1	Trimester one, 0 through 14 weeks, 0 days
Z2	Trimester two, 14 weeks 1 day through 28 weeks, 0 days
Z3	Trimester three, 28 weeks 1 day through delivery

For example: An IHCP member incurs the first antepartum visit at 16 weeks. Bill the claim with procedure code 59425 and a corresponding modifier of Z2. However, if the member's antepartum visit was at the member's seventh visit and the member was 17 weeks pregnant, bill with the procedure code 59426 and a corresponding modifier of Z2.