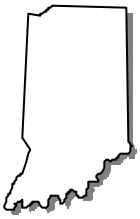

IMPORTANT INFORMATION

BR200206 FEBRUARY 5, 2002

To All Providers:

- The paper copy price of the *IHCP Provider Manual* recently increased to $121.60 per copy. All providers are entitled to one CD-ROM copy and one paper copy of the manual at no charge. Providers must request copies of the manual in writing and include a check for $121.60 for each **additional** paper copy. To avoid misapplication of payment and to ensure requests process accurately, write *IHCP Provider Manual* on the check memo line. Mail **all** publication requests to the following address:

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

  Table 1.1 indicates the charge and additional information needed for each IHCP publication requiring payment.

Table 1.1 – IHCP Request Charges and Locations

Publication	Charge	Additional Information
IHCP Provider Manual	$121.60 per paper copy No charge to providers for CD-ROM copies ($20 per CD-ROM for non-providers)	• Attach documentation for the request. • Write *IHCP Provider Manual* on the check memo line.
IHCP Fee Schedule	$43	• Attach documentation for the request. • Write *IHCP Fee Schedule* on the check memo line.
Remittance Advice Older Than One Year	$.10 per page	• Attach documentation stating the RA date being requested (including provider number and location). • Write *Remittance Advice Copy* on the check memo line.

- This clarifies information for peptic acid disease drugs published in bulletin *BT200148*, implementing the Indiana Rational Drug Program (IRDP). Prior authorization (PA) is required for therapeutic doses of an acid suppression agent beyond an acute treatment period of 90 days. The criteria for peptic acid drugs were effective January 7, 2002, and include H2 antagonists above maintenance dosing, sucralfate, and all proton pump inhibitors. PA for these drugs is to encourage a step-down process. Requests for PA will not be reviewed until April 7, 2002, after the first 90-day period is complete. Every subsequent 90-day period authorization will only be granted for the next lower dose of medication or frequency until a maintenance dosing of an H2 antagonist is achieved. Certain diagnoses may exempt a patient from this step-down requirement as outlined in *BT200148*.
- Hoosier Healthwise managed care information is now available on the www.indianamedicaid.com Web site. Visit the new pages for information about managed care contacts, frequently asked questions (FAQs), forms, primary medical provider (PMP) enrollment and disenrollment guidelines and much more, as well as up-to-date information concerning the mandatory Managed Care Organization (MCO) transition in certain Indiana counties. Just click the **Dr. Hoosier owl** to access the information.
- Effective February 5, 2002, the new hours for all EDS assistance phone lines are **8 a.m. to 5:30 p.m**. (EST).
- The *Claims Correction Form* (CCF) has been modified to allow additional space to describe requested information. This change begins with the RA dated February 5, 2002. This increased description will help providers determine the information that should be forwarded to EDS to complete adjudication of claims in a CCF status.

- EDS did routine, in-depth eligibility reconciliation between Indiana*AIM* and the Indiana Client Eligibility System (ICES) during the Martin Luther King, Jr. holiday weekend, January 19 through January 21, 2002. EDS was especially looking for members' eligibility segments open in Indiana*AIM*, but closed in the ICES. Members eligibility segments closed in ICES were closed in Indiana*AIM* with an end date of either January 31, 2002, or February 28, 2002. Providers must verify eligibility before any service is rendered.
- Following is an update to an article originally printed September 25, 2001, in *BR200139*.

  Edit 0232 – Rendering physician number is not in valid format, was inactivated for all crossover claims on July 7, 2000. EDS identified some duplicate claim payments made after that date. *Edit 0232* was reactivated effective September 14, 2001, to prevent additional duplicate payments. A systematic mass adjustment was finalized January 15, 2002, to recoup affected claims paid from July 7, 2000, through September 14, 2001. The adjustments denied when EDS did not have the Medicare information on file at the time of original claim adjudication. EDS is reviewing all crossover claims denied for *edit 0232* during this mass adjustment. If the correct Medicare information is now on the provider file, EDS will systematically reprocess the claim. Claims identified for reprocessing will appear on the RA dated February 19, 2002.

  If EDS does not have the correct Medicare information on file for both rendering and billing providers, the denied adjustments will not be reprocessed, and the provider must resubmit the crossover claim on paper or utilizing Provider Electronic Solutions. Additionally, future claims received from Medicare will not automatically crossover for Medicaid adjudication.
- The 2002 *Health Care Procedure Coding System* (HCPCS) and CPT code updates were loaded for crossover claims only on January 1, 2002. Providers should continue billing 2001 codes until April 1, 2002. The IHCP will deny claims submitted with 2002 codes for dates of service prior to April 1, 2002. Questions can be directed to the Health Care Excel Medical Policy Department at (317) 347-4500.

To All Dental Providers:

- The *Comprehensive oral examination (D0150)* and *Detailed and extensive oral evaluation – problem focused, by report (D0160)* codes are limited to reimbursement once a lifetime, per provider, per member. Once a provider uses *D0150* or *D0160* for an initial exam (new patient), the provider must bill a periodic exam code for the next oral examination. Periodic oral exams are limited to one per six months for members under 21 years old and to one per year for members 21 years old or older. If a provider submits either *D0150* or *D0160* more than once for a member, the claim denies with explanation of benefits (EOB) code 6226 – *Comprehensive or Detailed and extensive oral evaluations are limited to one per lifetime.*

To All Physicians, Nurse Practitioners, Clinics, Federally-Qualified Health Clinics, and Rural Health Clinics:

- Effective February 1, 2002, the $2.90 administration fee included in office administered injectable drug codes was removed. Exemptions to this revised policy include vaccines and toxoids that continue to include the $2.90 administration fee. Refer to bulletin *BT200151* for details about this revised policy.

To All Transportation Providers:

- Effective January 8, 2002, claims have been denied for *Edit 3012 – Transportation Exceeding Fifty Miles Requires a Prior Authorization*, even when a PA is on file. The problem was identified and corrected January 16, 2002. Impacted claims were systematically reprocessed or adjusted and appear in the RA dated February 5, 2002.