P R O V I D E R B U L L E T I N

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To: All Indiana Health Coverage Programs Providers

Subject: Indiana Health Coverage Programs Eligibility Verification System Update

Overview

The purpose of this bulletin is to inform providers of the addition of new audits to Indiana*AIM* and changes to the Eligibility Verification System (EVS). These changes will allow providers to access information about benefit limitations exhausted for the new audits and existing audits. Bulletin *BT200018,* dated June 1, 2000 indicated the EVS changes would take effect on June 8, 2000. **However, the information presented in this bulletin will become effective June 29, 2000**. The following topics are addressed in this bulletin:

- Upgrade to the AVR system
- Upgrade to the OMNI system and necessary download information
- Eligibility verification using electronic claims software

Currently, Automated Voice Response (AVR), OMNI 380 Terminal (OMNI) swipe card device, and National Electronic Claim Submission (NECS) can access eligibility information and benefit limitation information for three audits. These audits include one for transportation services (audit 6803, limit of 20 trips per rolling calendar year) and two for optometry services (audit 6600, lenses, limit two per year for age 18 and under and audit 6604, lenses, limit two every two years for individuals over age 18).

Effective June 29, 2000, AVR and OMNI will provide benefit limitation information for 34 additional services, including dental, chiropractic, podiatric, physical therapy evaluations and treatment, speech therapy evaluations and treatment, occupational therapy evaluations and treatment, audiological assessments, mental health, durable medical equipment, inpatient

rehabilitation services, and additional optometry services, including frames and vision exams. Table 1.1 lists specific audit information that will be available for each provider type. Table 1.2 provides specific messages that will be received on AVR when benefit limitations have been reached, and Table 1.3 provides the specific message that will be displayed on OMNI when benefit limitations have been reached.

Previously, providers had to write to EDS Written Correspondence to verify if a benefit limitation had been exhausted. Now providers will be able to verify if benefits have been exhausted for 37 audits via AVR or OMNI. Since information is now available on AVR and OMNI, providers will no longer need to write EDS Written Correspondence to determine if benefit limitations have been exhausted for the audits listed in Table 1.1.

Benefit limitation information for the 34 additional services will never be available for NECS users. Please see *Eligibility Verification Using Electronic Claims Software* in this bulletin for information on Provider Electronic Solutions, which will replace NECS.

NECS users that do not switch to Provider Electronic Solutions when it is made available later this year and OMNI users that do not download their terminals on or after June 29, 2000, will continue to only see the three benefit limitations that are currently displayed for all providers. However, information displayed will only be accurate for those provider types and specialties listed in Table 1.1. Bulletin *BT200020* provides more information about the OMNI download and a bulletin about Provider Electronic Solutions is forthcoming.

The specific benefit limitation information received will be determined by the provider's type and primary specialty. A provider will only receive benefit limitation information pertinent to its provider type and primary specialty.

For example, if a pediatric physician (provider type and primary specialty 31/335) inquired through OMNI or AVR to determine which benefits a member had exhausted, only the benefit limitation information for audits listed in Table 1.1 that specifically include provider type 31, will reflect paid claim activity. Therefore, if a Package C member has had 50 speech therapy visits in the past calendar year (audit 6116), the pediatrician would receive the following message on AVR, "The member has exhausted a benefit limit for therapy services. The limit for speech treatments is 50 units per calendar year." If no other benefit limitations have been reached, the provider will only receive this one message. However, the pediatrician will not be able to obtain information for benefit

limitations reached for durable medical equipment or any other audits for which the pediatrician's provider type and primary specialty is not listed in Table 1.1.

> ***Note: Please verify that you are using the correct provider number. Please use the billing provider number to obtain limitation information for most services. For medical office visits, also cross reference limitation information using the rendering provider number.***

All paid claims are counted in the benefit limitations regardless if they are fee-for-service or risk-based managed care. This includes both regular and shadow claims.

> *Note: Provider types listed in Table 1.1 include all specialties under that type unless specific specialties are noted. The provider's primary specialty will be used in these cases.*

> *Note: Audits in Table 1.1 represent HCFA-1500 claims unless otherwise noted.* ***Outpatient or home health therapy claims submitted on UB-92 claim forms will not be reflected in the benefit limitation information returned.*** *Providers are encouraged to track this information as failure to do so may impact covered services and reimbursement. Providers may also write the EDS Written Correspondence Unit for benefit limitation information related to claims filed on a UB-92 claim form.*
>
> *Please send written inquiries to the following address:*
> ***EDS Written Correspondence Unit***
> ***P.O. Box 7263***
> ***Indianapolis, IN 46207-7263***

Note: The OMPP has established two additional audits for optometry services. These include audit 6610, limit vision exams to one per year for members 18 and under and audit 6611, limit vision exams to one every two years for members over 18. These audits become effective June 29, 2000, and will be reflected on EVS. Prior to June 29, 2000, these services were subject to post-payment review.

The expanded EVS system gives the provider more information, however, EVS only reflects services paid up to that point in time. EVS does not reserve services for a provider or guarantee payment of services.

Note: Please see Appendix A *for a complete listing of provider types and specialties.*

Table 1.1 – Audit Information

Audit Number	Audit Description	Category of Audit	Claim Type	Provider Type/Specialty
6054	Initial audiological assessments are limited to one unit every 36 months	Audiology	HCFA-1500	08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 09 – Advance Practice Nurse 12 – School Corp 17 – Therapist 20 – Audiologist 31 – Physician – **excluding 31/330 and 31/339**
6100	Fifty units of therapeutic physical medicine treatments per year	Chiropractic	HCFA-1500	15 – Chiropractor
6101	Chiropractic office visits for new patients are limited to one unit per lifetime	Chiropractic	HCFA-1500	15 – Chiropractor
6105	One unit of full spine X-ray per year for chiropractor	Chiropractic	HCFA-1500	15 – Chiropractor
6111	Chiropractic office visits limited to five per year	Chiropractic	HCFA-1500	15 – Chiropractor
6112	Maximum of 14 – Chiropractic therapeutic physical medicine treatments per calendar year	Chiropractic	HCFA-1500	15 – Chiropractic

(Continued)

Table 1.1 – Audit Information

Audit Number	Audit Description	Category of Audit	Claim Type	Provider Type/Specialty
6122	Chiropractic therapeutic physical medicine treatments 15 through 50 require PA	Chiropractic	HCFA-1500	15 – Chiropractic
6033	Prophylaxis for institutionalized members of any age is limited to two units every six months	Dental	Dental Form	27 – Dentist 08/086 – Clinic
6209	Full mouth or Panoramic X-rays are limited to one unit every three years	Dental	Dental Form	27 – Dentist 08/086 – Clinic
6210	Prophylaxis for non-institutionalized members 20 years of age and under is limited to one unit every six months	Dental	Dental Form	27 – Dentist 08/086 – Clinic
6211	Periodic or limited oral evaluations are limited to one every six months	Dental	Dental Form	27 – Dentist 08/086 – Clinic
6212	Fluoride treatment is limited to one unit every six months for members ages 20 and younger (1 unit = 1 application)	Dental	Dental Form	27 – Dentist 08/086 – Clinic
6221	Periodontal root planing and scaling for non-institutionalized members three through 20 years of age is limited to four units every two years	Dental	Dental Form	27 – Dentist 08/086 – Clinic
6222	Periodontal root planing and scaling for institutionalized members of any age is limited to four units every two years	Dental	Dental Form	27 – Dentist 08/086 – Clinic
6223	Periodontal root planing and scaling for non-institutionalized members over 20 years of age is limited to four units per lifetime	Dental	Dental Form	27 – Dentist 08/086 – Clinic
6235	Prophylaxis for non-institutionalized members over 20 years of age is limited to one unit every 12 months	Dental	Dental Form	27 – Dentist 08/086 – Clinic

(Continued)

Table 1.1 – Audit Information

Audit Number	Audit Description	Category of Audit	Claim Type	Provider Type/Specialty
6113	DME limited to $2,000 per member per calendar year (prior authorization will override this audit)	DME	HCFA-1500	22 – Hearing Aid Dealer 25 – DME 24 – Pharmacy 04/040 – Rehab Facility
6114	DME limited to $5,000 per member per lifetime	DME	HCFA-1500	22 – Hearing Aid Dealer 25 – DME 24 – Pharmacy 04/040 – Rehab Facility
6119	Inpatient rehab services limited to 50 days per calendar year	Inpatient Rehab	UB-92	01 – Hospital
6012	Medical office visits are limited to 30 units per year	Medical	HCFA-1500	31 – Physician
6120	Outpatient mental health/ substance abuse services – Office visits, max 30 per calendar year without PA	Mental Health	HCFA-1500	08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 09/092 – Family Nurse Practitioner 09/093 – Nurse Practitioner 11 – Mental Health 12 – School Corp 31/339 – Psychiatrist
6121	Outpatient mental health/ substance abuse services – Office visits, max 50 per calendar year with PA	Mental Health	HCFA-1500	08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 09/092 – Family Nurse Practitioner 09/093 – Nurse Practitioner 11 – Mental Health 12 – School Corp 31/339 – Psychiatrist
6600	Initial or replacement lenses are limited to two lens per year for members 18 years of age and younger	Optometry	HCFA-1500	18 – Optometrist 19 – Optician 31/330 – Ophthalmologist
6601	Initial frames are limited to one unit per year for members 18 years of age and younger	Optometry	HCFA-1500	18 – Optometrist 19 – Optician 31/330 – Ophthalmologist
6603	Initial frames are limited to one unit every two years for members over 18 years of age	Optometry	HCFA-1500	18 – Optometrist 19 – Optician 31/330 – Ophthalmologist

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Table 1.1 – Audit Information

Audit Number	Audit Description	Category of Audit	Claim Type	Provider Type/Specialty
6604	Initial or replacement lenses are limited to two lens per two years for members over 18 years of age	Optometry	HCFA-1500	18 – Optometrist 19 – Optician 31/330 – Ophthalmologist
6610	Eye exams are limited to one per year for members 18 years of age and under	Optometry	HCFA-1500	18 – Optometrist 19 – Optician 31/330 – Ophthalmologist
6611	Eye exams are limited to one every two years for members over 18 years of age.	Optometry	HCFA-1500	18 – Optometrist 19 – Optician 31/330 – Ophthalmologist
6090	Office visit limited to one per year	Podiatry	HCFA-1500	14 – Podiatrist
6855	Routine foot care treatments are limited to six units per 12 months	Podiatry	HCFA-1500	14 – Podiatrist 31 – Physician, **excluding 31/330 and 31/339**
6060	Speech therapy evaluations are limited to one unit every 12 months	Therapy	HCFA-1500	04 – Rehab Facilities 08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 08/087 – Therapy Clinic 09/090 – Pediatric Nurse Practitioner 09/092 – Family Nurse Practitioner 09/093 – Nurse Practitioner 12 – School Corporation 17 – Therapist 31 – Physician, **excluding 31/330 and 31/339**
6115	Physical therapy services limited to 50 visits per calendar year	Therapy	HCFA-1500	04 – Rehab Facilities 08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 08/087 – Therapy Clinic 09/090 – Pediatric Nurse Practitioner 09/092 – Family Nurse Practitioner 09/093 – Nurse Practitioner 12 – School Corporation 17 – Therapist 31 – Physician, **excluding 31/330 and 31/339**

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Table 1.1 – Audit Information

Audit Number	Audit Description	Category of Audit	Claim Type	Provider Type/Specialty
6116	Speech therapy services limited to 50 visits per calendar year	Therapy	HCFA-1500	04 – Rehab Facilities 08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 08/087 – Therapy Clinic 09/090 – Pediatric Nurse Practitioner 09/092 – Family Nurse Practitioner 09/093 – Nurse Practitioner 12 – School Corporation 17 – Therapist 31 – Physician, **excluding 31/330 and 31/339**
6118	Occupational therapy services limited to 50 visits per calendar year	Therapy	HCFA-1500	04 – Rehab Facilities 08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 08/087 – Therapy Clinic 09/090 – Pediatric Nurse Practitioner 09/092 – Family Nurse Practitioner 09/093 – Nurse Practitioner 12 – School Corporation 17 – Therapist 31 – Physician, **excluding 31/330 and 31/339**
6752	Physical therapy evaluation limited to one unit every 12 months	Therapy	HCFA-1500	04 – Rehab Facilities 08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 08/087 – Therapy Clinic 09/090 – Pediatric Nurse Practitioner 09/092 – Family Nurse Practitioner 09/093 – Nurse Practitioner 12 – School Corporation 17 – Therapist 31 – Physician, **excluding 31/330 and 31/339**

(Continued)

Table 1.1 – Audit Information

Audit Number	Audit Description	Category of Audit	Claim Type	Provider Type/Specialty
6753	Occupational therapy evaluations are limited to one unit every 12 months	Therapy	HCFA-1500	04 – Rehab Facilities 08/080 – FQHC 08/081 – RHC 08/082 – Medical Clinic 08/084 – Nurse Practitioner Clinic 08/087 – Therapy Clinic 09/090 – Pediatric Nurse Practitioner 09/092 – Family Nurse Practitioner 09/093 – Nurse Practitioner 12 – School Corporation 17 – Therapist 31 – Physician, **excluding 31/330 and 31/339**
6803	One-way trips limited to 20 units every 12 months.	Transportation	HCFA-1500	26 – Transportation

Upgrade to the AVR System

Beginning June 29, 2000, the AVR will begin communicating additional benefit limitation audits based on a member's program eligibility effective on the first inquiry date and the provider's type and primary specialty. See Table 1.1 for an inclusive list of audits and descriptions with related claim and provider types. This table identifies limitation audits by the provider type/primary specialty.

> ***Note: A provider will only receive audit information for the provider type/primary specialty associated with the provider number that is used in its eligibility transactions.***

It is important to note that provider access to the AVR will not change. Changes only exist in the information communicated back to the provider about benefit limitations. Providers are reminded that it is important to listen to an entire message, as there may be information about a member's eligibility that may impact covered services and reimbursement.

Benefit limits only reflect claims processed and paid in Indiana*AIM* at the time of the call.

Table 1.2 outlines the modified benefit limitation component of AVR.

Table 1.2 – AVR System and Display of Benefit Limits

Benefit Limits		
Step	**When the AVR System says this...**	**...you do this:**
Step 4-0 Enter a member identification option	**"Please select one of the following recipient identification options followed by a pound sign:** **For Recipient number, press 1.** **For Social Security Number, press 2.** **For Medicare number, press 3."**	Press the number that corresponds to the information you have about the member, then press # If you enter **1**, continue to Step 4-1. If you enter **2**, continue to Step 4-2. If you enter **3**, continue to Step 4-3.
Step 4-1 Enter a member ID number	**"Please enter a Recipient number followed by a pound sign."**	Enter the Member number, then press **#.** Continue to Step 4-4.
Step 4-2 Enter a member SSN	**"Please enter a Social Security Number followed by a pound sign."**	Enter the SSN, then press #. Continue to Step 4-4.
Step 4-3 Enter a member Medicare number	**"Please enter a Medicare number followed by a pound sign."**	Enter the Medicare number, then press #. Continue to Step 4-4.
Step 4-4 Enter the "From" date-of-service	**"Please enter the 'From' date-of-service in a month, day, century, year format followed by a pound sign, or enter a pound sign only for today's date."**	Press # for today's date, or enter the "From" date-of-service in MMDDCCYY format, then press #. Continue to Step 4-5.
Step 4-5 Enter the "To" date-of-service	**"Please enter the 'To' date-of-service in a month, day, century, year format followed by a pound sign, or enter a pound sign only if the 'To' date-of-service is the same as the 'From' date-of-service."**	Press # if the "To" date-of-service is the same as the "From" date-of service already entered, or enter the "To" date-of-service in MMDDCCYY format, then press #. Continue to Step 4-6.
Step 4-6 Validate benefit limit information	**"Please wait while the requested information is retrieved."**	Do not press any keys. The AVR System is checking your information to make sure it is valid. Continue to Step 4-7.

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Table 1.2 – AVR System and Display of Benefit Limits

Benefit Limits		
Step	**When the AVR System finds this...**	**...you hear this message:**
Step 4-7 Benefit limit response	Member does not exist in the AVR system records.	**"Recipient number (RECIP-ID) is not on file. Please re-enter."** Continue to Step 4-1. **"Social Security Number (RECIP-SSN) is not on file. Please re-enter."** Continue to Step 4-2. **"Medicare number (RECIP-MCARE-NO) is not on file. Please re-enter."** Continue to Step 4-3.
	SSN or Medicare number also provides Member ID information.	**"Social Security Number (RECIP-SSN) refers to recipient number (RECIP-ID)."** **"Medicare number (RECIP-MCARE-NO) refers to recipient number (RECIP-ID)."**
	(No eligibility) The member is not eligible for services.	**"Recipient number (RECIP-ID), recipient last name (RECIP-LAST-NAME), recipient first name (RECIP-FIRST-NAME), is not eligible for services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC)."** Continue to Step 4-10.
		"Recipient number (RECIP-ID) has not exhausted benefit limits based on paid claims as of (CYCLE-TIME) on (CYCLE-DATE)." Continue to Step 4-10.
Step	**Related Audit**	**...you hear this message:**
Step 4-8 Benefit Limit exhausted response (Continued)		**"Recipient number (RECIP-ID) has exhausted limits for (NUM-SERV-LIMITS) benefit(s)."** Continue to Step 4-8.
	Audiology	
	Audit 6054	**" The member has exhausted a benefit limit for audiological services. The limit for assessments is one every 36 months."**
	Chiropractic	
	Audit 6100	**"The member has exhausted a benefit limit for chiropractic services. The limit for chiropractic medical treatments is 50 per year."**
	Audit 6101	**"The member has exhausted a benefit limit for chiropractic services. The limit for new patient office visits is one unit per lifetime."**

(Continued)

Table 1.2 – AVR System and Display of Benefit Limits

Benefit Limits		
Step 4-8 Benefit Limit exhausted response (Continued)	Audit 6105	**"The member has exhausted a benefit limit for chiropractic services. The limit for X-rays is one per year."**
	Audit 6111	**"The member has exhausted a benefit for chiropractic services. The limit for office visits is five per year."**
	Audit 6112	**"The member has exhausted a benefit limit for chiropractic services. The limit for chiropractic medical treatments is 14 per calendar year without PA."**
	Audit 6122	**"The member has exhausted a benefit limit for chiropractic services. Treatments 15 through 50 require PA."**
	Dental	
	Audit 6033	**"The member has exhausted a benefit limit for dental services. The limit for prophylaxis for members in a state institution is two units every six months."**
	Audit 6209	**"The member has exhausted a benefit limit for dental services. The limit for X-rays is one unit every three years."**
	Audit 6210	**"The member has exhausted a benefit limit for dental services. The limit for prophylaxis for 20 and under is one unit every six months."**
	Audit 6211	**"The member has exhausted a benefit limit for dental services. The limit for oral evaluations is one unit every six months."**
	Audit 6212	**"The member has exhausted a benefit limit for dental services. The limit for fluoride treatments is one unit every six months for 20 and under."**
	Audit 6221	**"The member has exhausted a benefit limit for dental services. The limit for root planing and scaling for 20 and under is four units every two years."**
	Audit 6222	**"The member has exhausted a benefit limit for dental services. The limit for root planing and scaling for members in a state institution is four units every two years."**

(Continued)

Table 1.2 – AVR System and Display of Benefit Limits

Benefit Limits		
Step 4-8 Benefit Limit exhausted response (Continued)	Audit 6223	**"The member has exhausted a benefit limit for dental services. The limit for root planing and scaling for over 20 is four units per lifetime."**
	Audit 6235	**"The member has exhausted a benefit limit for dental services. The limit for prophylaxis over 20 is one unit every 12 months."**
	Durable Medical Equipment	
	Audit 6113	**"The member has exhausted a limit for DME services. The limit is $2000 per calendar year."**
	Audit 6114	**"The member has exhausted a limit for DME services. The limit is $5000 per lifetime."**
	Inpatient Rehabilitation	
	Audit 6119	**"The member has exhausted a benefit limit for inpatient rehab services. The limit is 50 days of inpatient rehab services per year."**
	Medical	
	Audit 6012	**"The member has exhausted a benefit limit for medical office visits. The limit is 30 per year."**
	Mental Health	
	Audit 6120	**"The member has exhausted a benefit limit for Outpatient services. The limit for office visits is 30 per year without PA."**
	Audit 6121	**"The member has exhausted a benefit limit for Outpatient services. The limit for office visits is 50 per year with PA."**
	Optometry	
	Audit 6600	**"The member has exhausted a benefit limit for optometry services. The limit for lenses is two per year for 18 and under."**
	Audit 6601	**"The member has exhausted a benefit limit for optometry services. The limit for frames is one unit per year for 18 and under."**
	Audit 6603	**"The member has exhausted a benefit limit for optometry services. The limit for frames is one unit every two years for over 18."**
	Audit 6604	**"The member has exhausted a benefit limit for optometry services. The limit for lenses is two every two years for over 18."**

(Continued)

Table 1.2 – AVR System and Display of Benefit Limits

Benefit Limits		
Step 4-8 Benefit Limit exhausted response (Continued)	Audit 6610	**"The member has exhausted a benefit limit for optometry services. The limit for exams is one per year for 18 and under."**
	Audit 6611	**"The member has exhausted a benefit limit for optometry services. The limit for exams is one every two years for over 18."**
	Podiatry	
	Audit 6090	**"The member has exhausted a benefit limit for podiatry services. The limit for office visits is one per year."**
	Audit 6855	**"The member has exhausted a benefit limit for podiatry services. The limit for foot care is six units every 12 months."**
	Therapy	
	Audit 6060	**"The member has exhausted a benefit limit for therapy services. The limit for speech evaluations is one unit every 12 months."**
	Audit 6115	**"The member has exhausted a benefit limit for therapy services. The limit for physical treatments is fifty units per calendar year."**
	Audit 6116	**"The member has exhausted a benefit limit for therapy services. The limit for speech treatments is 50 units per calendar year."**
	Audit 6118	**"The member has exhausted a benefit limit for therapy services. The limit for occupational treatments is 50 units per calendar year."**
	Audit 6752	**"The member has exhausted a benefit limit for therapy services. The limit for physical evaluations is one unit every 12 months."**
	Audit 6753	**"The member has exhausted a benefit limit for therapy services. The limit for occupational evaluations is one unit every 12 months."**
	Transportation	
	Audit 6803	**"The member has exhausted a benefit limit for transportation services. The limit is 20 per rolling 12 month period."**

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Table 1.2 – AVR System and Display of Benefit Limits

Benefit Limits		
If the AVR System has provided information for the last (or only) benefit limit, the system continues the call flow at Step 4-10. If the system has information for another benefit limit, it pauses to give the user a chance to record the information from the last response, then continues at Step 4-9.		
Step #	**When the AVR System says this…**	**…you do this:**
Step 4-9 Benefit limit continuation option	**"There are (NUM-SERV-REMAINING) benefit limit(s) remaining.** **To hear the next benefit limit, press the pound sign.** **To skip the remaining benefit limit information, press 1 followed by the pound sign."**	Choose your response to hear the rest of the benefit limit information or skip it. If you press **#**, continue to Step 4-7. If you enter **1**, continue to Step 4-10.
Step 4-10 Benefit limit transaction verification number	**"Benefit limit verification number for this inquiry is (VERIF-NUMBER)."**	Note this number for future reference. Continue to Step 4-11.
Step 4-11 Benefit limit continuation menu option	**"To obtain benefit limit information on another recipient, press 1 followed by a pound sign.** **To return to the main menu, press the pound sign. If this concludes your call, please hang-up."**	Press the number that corresponds to the information you want to obtain, then press **#**. If you enter **1** and **#**, continue to Step 4-0. If you press **#**, continue to Step 2-0.

Upgraded OMNI System and Necessary Download Information

Beginning June 29, 2000, OMNI terminal downloads will be available and the OMNI swipe card system will begin displaying additional benefit limitation audits based on a member's program eligibility effective on the first inquiry date and the provider's type and specialty. See Table 1.1 for an inclusive list of audits and descriptions with related claim and provider types. This table identifies the limitation audits by provider type/primary specialty.

Note: A provider will only receive audit information for the provider type/specialty of the provider number used in the eligibility transactions.

*Note: To activate the benefit limitation changes on the OMNI terminal it is necessary for all providers using the OMNI to download their terminal **on June 29, 2000, or later**. Complete instructions for download procedures will be forwarded to all providers in bulletin BT200020.*

It is important to note that provider access to the OMNI swipe card system will not change. The only changes will be in the information communicated back to the provider about benefit limitations. Providers are reminded that it is important to review an entire message, as there may be information about a member's eligibility that may impact covered services and reimbursement.

Benefit limits only reflect claims processed and paid in Indiana*AIM*. If a member has not exhausted benefit limitations presented to the requesting provider type, or if there are no audits available to the inquiring provider type, the word **None** will appear as the **Benefit Limits Reached** indicator. Table 1.3 identifies the changes to the benefit limitation information for OMNI. The table has been divided into the following two categories:

- Displayed information
- Printed information

The OMNI response will vary depending on whether the user is using the display screen option or printing the information.

Table 1.3 – OMNI Changes

Benefit Limitation Information for the OMNI Swipe Card Machine			
Type	**Audit**	**Displayed Information**	**Printed Information**
Audiology	6054	AUDIO – ASSESS	AUDIOLOGY – ASSESSMENTS
Chiropractic	6100	CHIRO – MEDTREAT	CHIRO – MED – TREATMENTS
	6101	CHIRO –OFFICE	CHIROPRACTIC – OFFICE
	6105	CHIRO – XRAY	CHIROPRACTIC – XRAY
	6111	CHIRO – OFFICE	CHIROPRACTIC – OFFICE
	6112	CHIRO – MEDTREAT	CHIRO – MED – TREATMENTS
	6122	CHIRO TREAT W/ PA	CHIRO – MED – TREATMENTS W/ PA

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Table 1.3 – OMNI Changes

Benefit Limitation Information for the OMNI Swipe Card Machine			
Type	**Audit**	**Displayed Information**	**Printed Information**
Dental	6033	PROPHY-INST	DENTAL – PROPHYLAXIS – INST
	6209	FULL/PAN XRAYS	DENTAL – PROPHYLAXIS – INST
	6210	PROPHY N/INST <=20	DENTAL – PERIODONTAL – NON_INST <=20
	6211	ORAL EVALUATIONS	DENTAL – ORAL EVALUATIONS
	6212	FLUORIDE <= 20	DENTAL – FLUORIDE <= 20 YRS
	6221	PERIO N/INST <21	DENTAL – PERIODONTAL – NON_INST <21
	6222	PERIO – INST	DENTAL – PERIODONTAL – INST
	6223	PERIO N/INST >=21	DENTAL – PERIODONTAL – NON_INST >=21
	6235	PROPHY N/INST >20	DENTAL – PROPHYLAXIS – NON_INST >20
DME	6113	DME – $2000/YR	DME – $2000/YR
	6114	DME – $5000/LIFE	DME – $5000/LIFETIME
Inpatient	6119	INPATIENT – REHAB	INPATIENT – REHAB
Medical (Office Visits)	6012	OFFICE – VISITS	OFFICE – VISITS
Outpatient Mental Health/Substance Abuse	6120	OPMH/SUB AB N/PA	OUTPAT MNTL HLTH/SUB ABUSE –W/O PA
	6121	OPMH/SUB AB W/PA	OUTPAT MNTL HLTH/SUB ABUSE – W/ PA
Optometry	6600	OPT – LENSES <=18	OPTOMETRY – LENSES <=18YR
	6601	OPT – FRAMES <=18	OPTOMETRY – FRAMES <=18YR
	6603	OPT – FRAMES>18	OPTOMETRY – FRAMES >18YR
	6604	OPT – LENSES >18	OPTOMETRY – LENSES >18YR
	6610	OPT – EXAMS<=18	OPTOMETRY – EXAMS <=18YR
	6611	OPT – EXAMS>18	OPTOMETRY – EXAMS >18YR
Podiatry	6090	PODIA – OFFICE	PODIATRY – OFFICE
	6855	PODIA – FOOTCARE	PODIATRY – FOOTCARE
Therapy	6115	THER – PHYSICAL	THERAPY – PHYSICAL
	6116	THER – SPEECH	THERAPY – SPEECH
	6118	THER – OCCUPATNL	THERAPY – OCCUPATIONAL
Therapy (Evaluation)	6060	THER – SPEECH	THERAPY – SPEECH
	6752	THER – PHYSICAL	THERAPY – PHYSICAL
	6753	THER – OCCUPATNL	THERAPY – OCCUPATIONAL
Transportation	6803	TRANSPORTATION	TRANSPORTATION SERVICES

Eligibility Verification Using Electronic Claims Software

In the summer of 2000, EDS will release Provider Electronic Solutions, a new Windows-based software product for submitting batch claims electronically, verifying member eligibility, and submitting interactive pharmacy claims through point-of-sale (POS).

When Provider Electronic Solutions is distributed, providers may continue to use NECS software; however, NECS software **will not** be upgraded with future enhancements to the Electronic Claims System or Eligibility Verification System (EVS). This includes the additional benefit limitation audits outlined in this bulletin.

Provider Electronic Solutions is designed to replace the NECS software. Provider Electronic Solutions will display the additional benefit limitation audits outlined in this bulletin and will be upgraded with enhancements in the future.

Current NECS users should have already received a letter regarding Provider Electronic Solutions, dated March 20, 2000, along with an *Information Request Form*. Returning the *Information Request Form* ensures that the provider will receive the new Provider Electronic Solutions software. **To receive the Provider Electronic Solutions software, current NECS users must return the *Information Request Form* to EDS.** This form should be returned to the following address:

EDS
ECS Information Request Form
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

Future bulletins will provide more information about the distribution of the new Provider Electronic Solutions software to all providers interested in electronic claims submission.

For more information about Provider Electronic Solutions visit the Indiana Medicaid Web site at www.indianamedicaid.com or call the electronic claims submission help desk at (317) 488-5160.

Note: If you are receiving your eligibility information from a Value-added network (VAN), please direct all questions about these eligibility system changes to your specific vendor.

Contact Information

Providers are reminded that any bulletin referenced in this publication is available on the Indiana Medicaid Web site at www.indianamedicaid.com. If there are questions about the information in this bulletin, please call EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Appendix A: Provider Types and Specialties

Table A.1 provides a list of provider types and specialties.

Table A.1 – Provider Types

Provider Type	Description
01	Hospital
02	Ambulatory Surgical Center (ASC)
03	Extended Care Facility
04	Rehabilitation Facility
05	Home Health Agency
06	Hospice
07	Capitation Provider
08	Clinic
09	Advance Practice Nurse
10	Mid-level Practitioner
11	Mental Health Provider
12	School Corporation
13	Public Health Agency
14	Podiatrist
15	Chiropractor
16	Nurse
17	Therapist
18	Optometrist
19	Optician
20	Audiologist
21	Case Manager (Targeted)
22	Hearing Aid Dealer
23	Dietitian
24	Pharmacy
25	DME/Medical Supply Dealer
26	Transportation Provider
27	Dentist
28	Laboratory
29	X-ray Clinic
30	End-stage Renal Disease (RSD) Clinic

(Continued)

Table A.1 – Provider Types

Provider Type	Description
31	Physician
32	Waiver Provider
33	Non-Billing Waiver Case Manager

Table A.2 – Provider Specialties

Provider Specialty	Description
010	Acute Care
011	Psychiatric
012	Rehabilitation
020	Ambulatory Surgical Center (ASC)
030	Nursing Facility
031	ICF/MR
032	Pediatric Nursing Facility
033	Residential Care Facility
040	Rehabilitation Facility
050	Home Health Agency
060	Hospice
070	Risk-based Managed Care (RBMC)
071	Managed Care Organization (MCO)
072	Prepaid Health Plan (PHP)
073	Competitive Medical Plans (CMP)
080	Federally Qualified Health Clinic (FQHC)
081	Rural Health Clinic (RHC)
082	Medical Clinic
083	Family Planning Clinic
084	Nurse Practitioner Clinic
085	Title V Clinic
086	Dental Clinic
087	Therapy Clinic
090	Pediatric Nurse Practitioner
091	Obstetric Nurse Practitioner
092	Family Nurse Practitioner
093	Nurse Practitioner (Other)

(Continued)

Table A.2 – Provider Specialties

Provider Specialty	Description
094	Certified Registered Nurse Anesthesiologist (CRNA)
095	Certified Nurse Midwife
100	Physician Assistant
101	Anesthesiology Assistant
110	Outpatient Mental Health Clinic
111	Community Mental Health Center (CMHC)
112	Psychologist
113	Certified Psychologist
114	Health Service Provider in Psychology (HSPP)
115	Certified Clinical Social Worker
116	Certified Social Worker
117	Psychiatric Nurse
120	School Corporation
130	County Health Department
140	Podiatrist
150	Chiropractor
160	Registered Nurse (RN)
161	Licensed Practical Nurse (LPN)
162	Registered Nurse Clinical (RNC)
170	Physical Therapist
171	Occupational Therapist
172	Respiratory Therapist
173	Speech/Hearing Therapist
180	Optometrist
190	Optician
200	Audiologist
210	Care Coordinator for Pregnant Women
211	HIV Case Manager
212	CSHCS Care Coordinator
220	Hearing Aid Dealer
230	Registered Dietitian
240	Pharmacist
250	DME/Medical Supply Dealer

(Continued)

Table A.2 – Provider Specialties

Provider Specialty	Description
260	Ambulance
261	Air Ambulance
262	Bus
263	Taxi
264	Common Carrier (Ambulatory)
265	Common Carrier (Non-ambulatory)
266	Family Member
270	Endodontist
271	General Dentistry Practitioner
272	Oral Surgeon
273	Orthodontist
274	Pediatric Dentist
275	Periodontist
276	Pedodontist
277	Prosthesis
280	Independent Lab
281	Mobile Lab
290	Freestanding X-ray Clinic
291	Mobile X-ray Clinic
300	Freestanding Renal Dialysis Clinic
310	Allergist
311	Anesthesiologist
312	Cardiologist
313	Cardiovascular Surgeon
314	Dermatologist
315	Emergency Medicine Practitioner
316	Family Practitioner
317	Gastroenterologist
318	General Practitioner
319	General Surgeon
320	Geriatric Practitioner
321	Hand Surgeon
322	Internist

(Continued)

Table A.2 – Provider Specialties

Provider Specialty	Description
323	Neonatologist
324	Nephrologist
325	Neurological Surgeon
326	Neurologist
327	Nuclear Medicine Practitioner
328	Obstetrician/Gynecologist
329	Oncologist
330	Ophthalmologist
331	Orthopedic Surgeon
332	Otologist, Laryngologist, Rhinologist
333	Pathologist
334	Pediatric Surgeon
335	Pediatrician
336	Physical Medicine and Rehabilitation Practitioner
337	Plastic Surgeon
338	Proctologist
339	Psychiatrist
340	Pulmonary Disease Specialist
341	Radiologist
342	Thoracic Surgeon
343	Urologist
344	General Internist
345	General Pediatrician
346	Dispensing Physician
350	Aged and Disabled Waiver
351	Autism Waiver
352	ICF/MR Waiver
353	OBRA/DD
354	Medically Fragile Children's Waiver
355	Non-Billing Case Manager
356	Waiver-Traumatic Brain Injury