Monthly News

Indiana Health Coverage Programs

www.indianamedicaid.com

Provider News NL200405 May 2004

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Frequently Used Acronyms

ACH	Automated Clearing House
AVR	Automated Voice Response
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
EFT	Electronic Funds Transfer
EVS	Eligibility Verification Systems
HCE	Health Care Excel
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
MCO	Managed Care Organization
OMPP	Office of Medicaid Policy and Planning
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PMP	Primary Medical Provider
RBMC	Risk-Based Managed Care
TPL	Third Party Liability

Provider News

2004 HCPCS Code Corrections

Table 1 lists corrections to 2004 HCPCS codes published in IHCP provider bulletin *BT200401*, dated February 13, 2004.

CPT code 99553, *Home infusion for tocolytic therapy, per visit*, was a 2004 HCPCS deleted code and crosswalked to CPT codes 99601 and 99602 effective January 1, 2004.

Table 1 – HCPCS Codes

Code	Description	Coverage
99601	Home infusion/specialty drug administration, per visit (up to 2 hours):	Covered for all programs, covered for Package C
99602	each additional hour (list separately in addition to primary procedure)	Covered for all programs, covered for Package C

Restricted Card Program: Referrals and Prescriptions

PCPs* are responsible for managing the care of members in the Restricted Card Program. The restricted member's PCP is responsible for sending notice of the referrals to the referred specialists and HCE. This notice must indicate the name of the specialist and the duration of the referral. If no end date is indicated on the referral, HCE enters the referral for up to 12 months. When HCE receives the referral, the specialist is added to the member's Lock-In List. Inclusion on the list allows both the PCP and the specialist to write prescriptions for the restricted member.

Direct questions about the Restricted Card Program to:

Health Care Excel
Restricted Card Program
P.O. Box 531700
Indianapolis, IN 46253-1700
800-457-4515
Fax: 317-347-4535

**In the context of the Restricted Card Program, PCP refers to the physician who manages IHCP members in the Restricted Card Program. The PCP may be the same physician as the PMP for restricted card members who are also in one of the Hoosier Healthwise or Medicaid Select managed care programs.*

Electronic Funds Transfer

Providers attempting to use the 835 Health Care Claim Payment Remittance Advice transaction with the electronic ACH payment file have been unable to use EFT for this functionality. To perform electronic reconciliation, the IHCP is modifying the ACH file to include the ACH addenda record per the recommendation in the 835 Implementation Guide. Providers can choose to accept the ACH addenda record from their bank. This does not affect electronic payments for providers that do not require or choose to not receive the ACH addenda record.

Banner page articles will announce when the new file is available from the provider's financial institution. Providers choosing to use the ACH file should contact their software vendor for additional information.

Eligibility Verification

Effective June 1, 2004, the IHCP is implementing changes to the EVS. These changes will result in the ability of chiropractic, dental, and DME providers to inquire about additional benefit limitations and for all providers to receive additional level of care information in the eligibility response. In addition to nursing home residency information, the level of care information provided by the EVS will also identify hospice or waiver level of care. Providers requiring specific information about dates of each level of care segment and the specific type of hospice or waiver assignment must contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278. If a specific level of care cannot be identified for the period searched, providers may contact HCE for hospice level of care or the waiver or long-term care units at the State for the appropriate information.

AVR and Web interChange will be updated automatically with no provider action required. OMNI users wishing to use the new benefit and eligibility information must download new OMNI software that includes these updates. Providers using other software packages for batch or interactive 270/271 eligibility verification must contact their software vendors to ensure that the new software is being used.

There have been recent inquiries about eligibility information shown on Web interChange about a member's IHCP enrollment. Providers have questioned the umbrella heading that a member is *eligible* for Hoosier Healthwise but does not indicate that the member is in managed care. Hoosier Healthwise encompasses several benefit packages and eligibility classifications, some of which are not managed care. Members may be eligible for managed care but not enrolled in a managed care program.

The following is an example of what a provider may see on Web interChange when verifying eligibility:

Member is eligible from April 1, 2004 to April 1, 2004 for HOOSIER HEALTHWISE PACKAGE A STANDARD

Inquiry completed at 2:40 11 P.M. on 4/1/2004

Member Name Jane Doe

Managed Care NO

The response in this heading states the person is in Hoosier Healthwise Package A and the "no" in the managed care field indicates no enrollment in a managed care plan. When a provider encounters this message, the provider should refer to the line that specifies managed care to determine whether the member is enrolled in managed care. In the above example as of April 1, 2004, the member was NOT enrolled in any of the Hoosier Healthwise managed care programs. As a result, the member is Traditional Medicaid for billing purposes.

In addition, if the member is eligible for *Medicaid Select*, the provider will see the following:

Member is eligible from April 1, 2004 to April 1, 2004 for Traditional Medicaid

Inquiry completed at 2:40 11 P.M. on 4/1/2004

Member Name Jane Doe

Managed Care NO

If the member is enrolled in *Medicaid Select*, the provider will see the following:

Member is eligible from April 1, 2004 to April 1, 2004 for Traditional Medicaid

Inquiry completed at 2:40 11 P.M. on 4/1/2004

Member Name Jane Doe.

Managed Care Medicaid Select Primary Care Case Management (PCCM)

Provider Name Marcus Welby

Phone XXX-XXX-XXXX

For more information, contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278.

Transportation Services Policy Clarification

This article clarifies transportation policy issues including information about neonatal ambulance transport, mileage, waiting time, mapping systems, and scheduled non-emergency ambulance transportation.

A transportation code set was established to ensure appropriate reimbursement for transportation codes. Audits based upon current coverage and coding guidelines were developed for review of codes billed on Medicaid claims to determine if they are appropriate for the provider specialty or type. Providers must ensure that they are enrolled as the correct provider specialty with the IHCP. Enrolled providers billing within current guidelines should not experience difficulty associated with implementation of these audits. Table 4 lists the transportation code set.

Neonatal Transport

Ambulance providers requested clarification of *405 IAC 5-30-5 (2)* about neonatal ambulance transport. This rule requires recognition of neonatal ambulances by emergency medical services. However, the Emergency Medical Services Commission (EMSC) does not recognize a separate category for neonatal ambulances. Therefore, the IHCP will not apply this requirement.

Mileage

Transportation providers must use the shortest and most efficient route to and from the destination. Transportation providers formerly were required to bill for all mileage, including the first 10 miles, even though claims for less than 10 miles were denied reimbursement. Effective immediately, providers are not required to report mileage for claims less than 10 miles. Providers still must bill total mileage for claims more than 10 miles.

Mileage Units

The IHCP reimburses commercial ambulatory, non-taxi, and non-ambulatory providers for loaded mileage when the provider transports a member more than 10 miles one way. Providers must bill the IHCP for whole units only. Partial mileage units must be rounded to the nearest whole unit. For example, if the provider transports a member between 15.5 miles and 16.0 miles, the provider must bill 16 miles. If the provider transports a member between 15.0 miles and 15.4 miles, the provider must bill 15 miles.

Waiting Time

Waiting time is not reimbursable unless the member is transported more than 50 miles one way. PA must also be obtained for the waiting time by documenting the medical necessity of the trip.

The IHCP does not cover the first 30 minutes of waiting time. However, total waiting time must always be included on the claim, or the claim may not pay appropriately.

One unit of service equals 30 minutes of waiting time for all procedure codes used to bill waiting time. Partial 30-minute increments must be rounded up to the next unit when the provider waits between 15 and 30 minutes. For example, if the provider waits 45 minutes, the provider must bill for two units. If the provider waits less than 15 minutes, the 30-minute increment must be rounded down. For example, if the provider waits one hour and 10 minutes, the provider must bill for two units.

Waiting time is reimbursable only when the vehicle is parked outside the medical service provider awaiting the return of the member to the vehicle.

Mileage Documentation Requirements

Effective immediately, transportation providers may document mileage using mapping software programs or odometer readings. This documentation must include the date the transportation service was performed and the specific starting and destination address. If mapping software is used, it must indicate the shortest route. Transportation providers are responsible for maintaining these records for possible post-payment review.

New Procedure Code for Non-Emergency Transportation

Ambulance providers requested that the IHCP modify a code to allow billing for ambulatory or non-ambulatory services when basic life support (BLS) or advanced life support (ALS) transports are not medically necessary. Procedure code modifiers **U3 (CAS)** and **U5 (NAS)** have been added to HCPCS codes **A0426** and **A0428**, and the rate has been adjusted to reflect the appropriate level of service provided. The new modifiers are effective April 1, 2004, and were published in banner page *BR200412*, dated March 23, 2004. Table 2 lists descriptions of these codes and the adjusted rates.

These new codes must be used **only** when an ambulance provider receives a call for transportation to a scheduled non-emergency service when an ambulance is not medically necessary. Ambulance providers must continue billing **A0425 U1** *Ground mileage, per statute mile; ALS*, and **A0425 U2** *Ground mileage, per statute mile; BLS*, to be reimbursed for mileage.

New codes **A0426 U3**, **A0426 U5**, **A0428 U3**, and **A0428 U5** are subject to the 20 trip limitation and are included in audit 6803, *Transportation: one way trips in excess of 20[trips] require prior authorization*, and edit 3012, *Transportation exceeding fifty miles requires prior authorization*. These services are non-emergency transportation and do not require the use of ambulance services. The IHCP will closely monitor these new codes for appropriate use.

Table 2 – Non-Emergency Transportation Provided by ALS or BLS Ambulance

Procedure Code	Description	IHCP Rate
A0426 U3	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); CAS	$10
A0426 U5	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); NAS	$20
A0428 U3	Ambulance service, basic life support, non-emergency transport; CAS	$10
A0428 U5	Ambulance service, basic life support, non-emergency transport; NAS	$20

Table 3 lists coding changes for billing of certain transportation services effective July 1, 2004. These changes are based on a review of the transportation code set.

Table 3 – Transportation Services Coding Changes

Procedure Code	Replacement Procedure Code
S0215	A0425 U1-ALS Ground Mileage, per statute mile A0425 U2-BLS Ground Mileage, per statute mile A0425 U3-CAS Ground mileage, per statute mile A0425 U5-NAS Ground mileage, per statute mile
T2001 TK	T2001
T2003 U9	T2003
T2004 TT	T2004

Covered Transportation Services

Reimbursement for transportation services is limited to the codes listed in Table 4. These codes are also limited by provider specialty. Only the following specialty(s) listed with the code are reimbursed for the service:

- 260 Ambulance Provider
- 261 Air Ambulance Provider
- 262 Bus Provider
- 263 Taxi Provider
- 264 Common Carrier-Ambulatory
- 265 Common Carrier-Non Ambulatory
- 266 Family Member Provider

Table 4 – Transportation Code Set

Procedure Code	PA Required	Description	Provider Specialty
A0090	No	Non-emergency transportation, per mile-vehicle provided by individual (family member, self, neighbor) with vested interest	266
A0100 UA	No	Taxi, rates non-regulated, 0-5 miles	263, 264
A0100 UB	No	Taxi, rates non-regulated, 6-10 miles	263, 264
A0100 UC	No	Taxi, rates non-regulated, 11 or more miles	263, 264
A0100 TK UA	No	Taxi, rates non-regulated, 0-5 miles for accompanying parent/attendant	263, 264
A0100 TK UB	No	Taxi, rates non-regulated, 6-10 miles for accompanying parent/attendant	263, 264
A0100 TK UC	No	Taxi, rates non-regulated, 11 or more miles for accompanying parent/attendant	263, 264
A0100 TT UA	No	Taxi, rates non-regulated, 0-5 miles for multiple passengers	263, 264
A0100 TT UB	No	Taxi, rates non-regulated, 6-10 miles for multiple passengers	263, 264
A0100 TT UC	No	Taxi, rates non-regulated, 11 or more miles for multiple passengers	263, 264
A0100 U4	No	Non-emergency transportation; taxi, suburban	263, 264
A0110	Yes	Non-emergency transportation and bus, intra or interstate carrier	262
A0130	No	Non-emergency transportation, wheel chair van base rate	265
A0130 TK	No	Non-emergency transportation, wheel chair van base rate; extra patient or passenger, non-ambulance	265
A0130 TT	No	Non-emergency transportation, wheel chair van base rate; individualized service provided to more than one patient in same setting	265
A0140	Yes	Non-emergency transportation and air travel (private or commercial), intra or interstate	261
A0225	No	Ambulance service, neonatal transport, base rate, emergency transport, one-way	260
A0420 U1	No	Ambulance waiting time ALS, one-half (1/2) hour increments	260, 261
A0420 U2	No	Ambulance waiting time BLS, one-half (1/2) hour increments	260, 261
A0422	No	Ambulance (ALS and BLS) oxygen and oxygen supplies, life-sustaining situation	260, 261

(Continued)

Table 4 – Transportation Code Set

Procedure Code	PA Required	Description	Provider Specialty
A0424	No	Extra ambulance attendant, ground (ALS or BLS) or air (rotary and fixed wing)	260, 261
A0425 U1	No	Ground mileage, per statute mile; ALS	260
A0425 U2	No	Ground mileage, per statute mile; BLS	260
A0425 U3	No	Ground mileage, per statute mile; CAS	260, 263, 264,
A0425 U5	No	Ground mileage, per statute mile; NAS	260, 263, 265
A0426	No	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)	260
A0426 U3	No	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); CAS	260
A0426 U5	No	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); NAS	260
A0427	No	Ambulance service, advanced life support, emergency, level 1 (ALS1-emergency)	260
A0428	No	Ambulance service, basic life support, non-emergency transport; BLS	260
A0428 U3	No	Ambulance service, basic life support, non-emergency transport; CAS	260
A0428 U5	No	Ambulance service, basic life support, non-emergency transport; NAS	260
A0429	No	Ambulance service, basic life support, emergency transport, (BLS-emergency)	260
A0430	Yes	Ambulance service, conventional air service, transport, one way (fixed wing)	261
A0431	Yes	Ambulance service, conventional air service, transport, one way (rotary wing)	261
A0433	No	Advanced ALS (Level 2)	260
A0999	Yes	Unlisted ambulance service	260, 261
T2001	No	Non-emergency transportation, patient attendant/escort	263, 264
T2003	No	Non-emergency transportation, encounter/trip	263, 264
T2004	No	Non-emergency transportation, commercial carrier, multi-pass	263, 264
T2007 U3	No	Transportation waiting time, air ambulance and non-emergency vehicle, one- half (1/2) hour increments; CAS	263, 264
T2007 U5	No	Transportation waiting time, air ambulance and non-emergency vehicle, one- half (1/2) hour increments; NAS	263, 265

Additional Information

Direct questions about this information to the HCE Medical Policy Department at (317) 347-4500.

Cognitive Therapy Services

The IHCP identified that claims representing cognitive therapy services are being billed for diagnoses not appropriate for those services. *IAC 405 5-29-1 (25) (I)* states that cognitive rehabilitation is a noncovered service, except for treatment of traumatic brain injury (TBI). CPT codes 97532 – *Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on one) patient contact by the provider, each 15 minutes*, and 97533 – *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes*, are limited to the specific TBI diagnoses listed in Table 5. The IHCP will deny claims submitted without the proper diagnosis code.

Table 5 – Traumatic Brain Injury ICD-9-CM Codes

ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code
348.1	800.01	800.02	800.03	800.04
800.05	800.06	800.09	800.10	800.11
800.12	800.13	800.14	800.15	800.16
800.19	800.20	800.21	800.22	800.23
800.24	800.25	800.26	800.29	800.30
800.31	800.32	800.33	800.34	800.35
800.36	800.39	800.40	800.41	800.42
800.43	800.44	800.45	800.46	800.49
800.50	800.51	800.52	800.53	800.54
800.55	800.56	800.59	800.60	800.61
800.62	800.63	800.64	800.65	800.66
800.69	800.70	800.71	800.72	800.73
800.74	800.75	800.76	800.79	800.80
800.81	800.82	800.83	800.84	800.85
800.86	800.89	800.90	800.91	800.92
800.93	800.94	800.95	800.96	800.99
801.00	801.01	801.02	801.03	801.04
801.05	801.06	801.09	801.10	801.11
801.12	801.13	801.14	801.15	801.16
801.19	801.20	801.21	801.22	801.23
801.24	801.25	801.26	801.29	801.30
801.31	801.32	801.33	801.34	801.35
801.36	801.39	801.40	801.41	801.42
801.43	801.44	801.45	801.46	801.49
801.50	801.51	801.52	801.53	801.54
801.55	801.56	801.59	801.60	801.61

(Continued)

Table 5 – Traumatic Brain Injury ICD-9-CM Codes

ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code
804.62	801.63	801.64	801.65	801.66
801.69	801.70	801.71	801.72	801.73
801.74	801.75	801.76	801.79	801.80
801.81	801.82	801.83	801.84	801.85
801.86	801.89	801.90	801.91	801.92
801.93	801.94	801.95	801.96	801.99
803.00	803.01	803.02	803.03	803.04
803.05	803.06	803.09	803.10	803.11
803.12	803.13	803.14	803.15	803.16
803.19	803.20	803.21	803.22	803.23
803.24	803.25	803.26	803.29	803.30
803.31	803.32	803.33	803.34	803.35
803.36	803.39	803.40	803.41	803.42
803.43	803.44	803.45	803.46	803.49
803.50	803.51	803.52	803.53	803.54
803.55	803.56	803.59	803.60	803.61
803.62	803.63	803.64	803.65	803.66
803.69	803.70	803.71	803.72	803.73
803.74	803.75	803.76	803.79	803.80
803.81	803.82	803.83	803.84	803.85
803.86	803.89	803.90	803.91	803.92
803.93	803.94	803.95	803.96	803.99
804.00	804.01	804.02	804.03	804.04
804.05	804.06	804.09	804.10	804.11
804.12	804.13	804.14	804.15	804.16
804.19	804.20	804.21	804.22	804.23
804.24	804.25	804.26	804.29	804.30
804.31	804.32	804.33	804.34	804.35
804.36	804.39	804.40	804.41	804.42
804.43	804.44	804.45	804.46	804.49
804.50	804.51	804.52	804.53	804.54
804.55	804.56	804.59	804.60	804.61
804.62	804.63	804.64	804.65	804.66
804.69	804.70	804.71	804.72	804.73
804.74	804.75	804.76	804.79	804.80
804.81	804.82	804.83	804.84	804.85

(Continued)

Table 5 – Traumatic Brain Injury ICD-9-CM Codes

ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code	ICD-9-CM Code
804.86	804.89	804.90	804.91	804.92
804.93	804.94	804.95	804.96	804.99
851.00	851.01	851.02	851.03	851.04
851.05	851.06	851.09	851.10	851.11
851.12	851.13	851.14	851.15	851.16
851.19	851.20	851.21	851.22	851.23
851.24	851.25	851.26	851.29	851.30
851.31	851.32	851.33	851.34	851.35
851.36	851.39	851.40	851.41	851.42
851.43	851.44	851.45	851.46	851.49
851.50	851.51	851.52	851.53	851.54
851.55	851.56	851.59	851.60	851.61
851.62	851.63	851.64	851.65	851.66
851.69	851.70	851.71	851.72	851.73
851.74	851.75	851.76	851.79	851.80
851.81	851.82	851.83	851.84	851.85
851.86	851.89	851.90	851.91	851.92
851.93	851.94	851.95	851.96	851.99
852.00	852.01	852.02	852.03	852.04
852.05	852.06	852.09	852.10	852.11
852.12	852.13	852.14	852.15	852.16
852.19	852.20	852.21	852.22	852.23
852.24	852.25	852.26	852.29	852.30
852.31	852.32	852.33	852.34	852.35
852.36	852.39	852.40	852.41	852.42
852.43	852.44	852.45	852.46	852.49
852.50	852.51	852.52	852.53	852.54
852.55	852.56	852.59	853.00	853.01
853.02	853.03	853.04	853.05	853.06
853.09	853.10	853.11	853.12	853.13
853.14	853.15	853.16	853.19	854.00
854.01	854.02	854.03	854.04	854.05
854.06	854.09	854.10	854.11	854.12
854.13	854.14	854.15	854.16	854.19
907.0	994.1	997.01		

Address Change for Non-Pharmacy and TPL Refunds

Effective February 1, 2004, the remittance address for non-pharmacy and TPL refunds changed. To correct billing errors and satisfy accounts receivable, please remit non-pharmacy and TPL refunds to the following address:

EDS Refunds
P. O. Box 2303, Dept. 130
Indianapolis, IN 46206-2303

Providers **must** include the department number in the address. If a refund check is submitted to a different P.O. Box than listed above or if the department number is missing, a delay in processing checks and adjustments could occur. The following mailing address for non-cashed IHCP checks remains unchanged:

EDS Finance Department
950 N. Meridian St.
Suite 1150
Indianapolis, IN 46204-4288

2004 Second Quarter Workshops for Medicaid and Hospice Providers

The OMPP, Children's Health Insurance Program (CHIP), and EDS offer IHCP 2004 second quarter workshops free of charge. Sessions are offered at several locations in Indiana. Table 6 lists the time, name, and description of each session. The schedule allows for a lunch period from noon until 1 p.m.; however, lunch is not provided. **Seating is limited in all locations**. **Registrations are processed in the order received and does not guarantee a spot at the workshop**. Confirmation letters are sent upon receipt of registrations. If a confirmation letter is not received, the seating capacity has been reached for that workshop.

Table 6 – Workshop Session Times, Name, and Description

Time	Session	Description
8:30 a.m. to 10:45 a.m.	Medicaid 201	This session conveys all the information providers need to know about third party liability (TPL), the Medicare-Medicaid interaction, and the IHCP managed care programs including *Medicaid Select*. The session provides information about all aspects of TPL from health maintenance organization (HMO) copayments to blanket denials. There is a strong focus on Medicare and Medicaid related claims, and a review of the common claim denials associated with the IHCP managed care programs. This course is designed for insurance clerks who have experience in IHCP claim submission procedures, payment posting and claim resolution.
11 a.m. to noon	Medicaid and Managed Care Roundtable	This session allows providers the opportunity to ask questions about the IHCP. Representatives from AmeriChoice and EDS field consultants will be present at all roundtable discussions; and, where applicable, representatives from the MCOs will be present.
Noon to 1 p.m.	Lunch Break	Lunch is not provided
1 p.m. to 2:30 p.m.	The Adjustment Process	This session will help providers complete the adjustment form, the different types of adjustments and how to read the remittance advice. This session is recommended for new and seasoned billers.
2:45 p.m. to 4:15 p.m.	Hospice	This session will discuss all aspects of the hospice process from timely authorization to claim submission. This session is for providers rendering hospice services. **Nursing facility providers are encouraged to attend this session.**

Table 7 lists the dates and Indiana locations for each workshop.

Table 7 – Workshop Dates, Deadlines, and Locations

Workshop Date	Registration Deadline	Location
May 25, 2004	May 18, 2004	St. Joseph Regional Medical Center, South Bend Education Center 801 East LaSalle Avenue
June 3, 2004	May 27, 2004	Wishard Memorial Hospital, Indianapolis Myers Auditorium 1001 West 10th Street
June 16, 2004	June 9, 2004	Deaconess Hospital, Evansville Bernard Schnacke Auditorium 600 Mary Street
June 17, 2004	June 10, 2004	Bloomington Hospital, Bloomington Auditorium 601 West Second Street
June 22, 2004	June 15, 2004	Columbus Regional Hospital, Columbus Kroot Auditorium 2400 East 17th Street
June 24, 2004	June 17, 2004	Lutheran Hospital, Fort Wayne Kachmann Auditorium 7950 West Jefferson Boulevard

All workshops begin promptly at 8:30 a.m. local time. General directions to workshop locations are available on the IHCP Web site at www.indianamedicaid.com. To access directions on the Web site click **Provider Services/Education Opportunities/Provider Workshops**. Consult a map or other location tool for specific directions to the exact location.

Workshops are presented free of charge to providers and seating for the workshops is limited to two registrants per provider number. Fax completed registration forms to EDS at (317) 488-5376. EDS processes registrations chronologically based on the date of the workshop. A letter or fax confirming registration will be sent before the workshop. Direct questions about the workshop to a field consultant at (317) 488-5072.

For comfort, business casual attire is recommended. Consider bringing a sweater or jacket due to the possible room temperature variations.

The *Provider Workshop Registration* form can be found on page 20 of this newsletter. Please print or type the information requested on the registration form. List one registrant per form.

Chiropractic Services

Eligibility Verification

Effective June 1, 2004, the IHCP is implementing changes to the EVS. AVR and Web interChange have been updated to indicate if Package C or non-Package C members have met the limitation for routine chiropractic office visits. The EVS will also indicate if the member has reached the benefit limit for initial chiropractic office visits.

OMNI terminals and other eligibility verification software must be updated to provide additional information about benefit limitations for chiropractic services. Table 8 lists service type codes and benefit limitations for OMNI users who complete the upgraded chiropractic limitation information download. The information in Table 8 is effective June 1, 2004.

Table 8 – Benefit Limitations Effective June 1, 2004

Provider Type	Service Type Code	Benefit Limitation Information
Chiropractor	34	Chiropractic initial office visits
Chiropractor	33	Chiropractic treatments
Chiropractor	4	Chiropractic x-rays
Chiropractor	81	Chiropractic routine office visits

Dental Services

Eligibility Verification

Effective June 1, 2004, the IHCP is enhancing EVS to include the total dollars spent toward the $600 annual dental cap and benefit limitations for sealants. Dental providers can now obtain total dollars spent toward the $600 annual cap. This dollars are allocated to the cap from paid claims. Claims not yet received or adjudicated are not reflected in the amount shown. After the $600 cap amount is met, the EVS will show a *Benefit Exceeded* note for the service for any date during the calendar year following the date the cap was met.

Using EVS, dental providers can obtain benefit limits for dental sealants by tooth number. Benefit limitations are identified from paid claims data. When a sealant has been paid, the EVS reports the *Tooth Number Sealed* and reports the benefit for that tooth number as *Exceeded.* AVR and Web interChange will be updated automatically with no provider action required. OMNI users must download new OMNI software that includes these updates. Providers using other software packages for eligibility verification must contact their software vendors to ensure that the new software is being used. Table 9 lists dental benefit limitations effective June 1, 2004.

Table 9 – Benefit Limitations Effective June 1, 2004

Provider Type	Service Type Code	Benefit Limitation Information
Dental	28	Fluoride treatments
Dental	35	Oral exams
Dental	24	Periodontal root planning
Dental	41	Preventive - prophylaxis
Dental	25	Restorative – annual dental cap
Dental	23	X-rays – full mouth or panoramic
Dental	60	Dental sealants – lifetime cap

Net Charge Missing

The IHCP identified a high volume of denials for edit *0401 – Net Charge Missing*. For claims to adjudicate properly, net charge is required in the *Patient Pays* portion of field 59 on the *ADA 1999 version 2000 Dental Claim Form*. The net charge equals the total charges, indicated in the *Total Fee* portion of field 59, minus the TPL paid amount, indicated in the *Payment by Other Plan* portion of field 59. Provider bulletin *BT200364*, dated September 30, 2003, also contains this information. The sample claim form in Figure 1 illustrates how to complete the required fields on the claim form. Claims submitted without a net charge will deny for edit *0401 – Net Charge Missing*. Direct questions about this to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

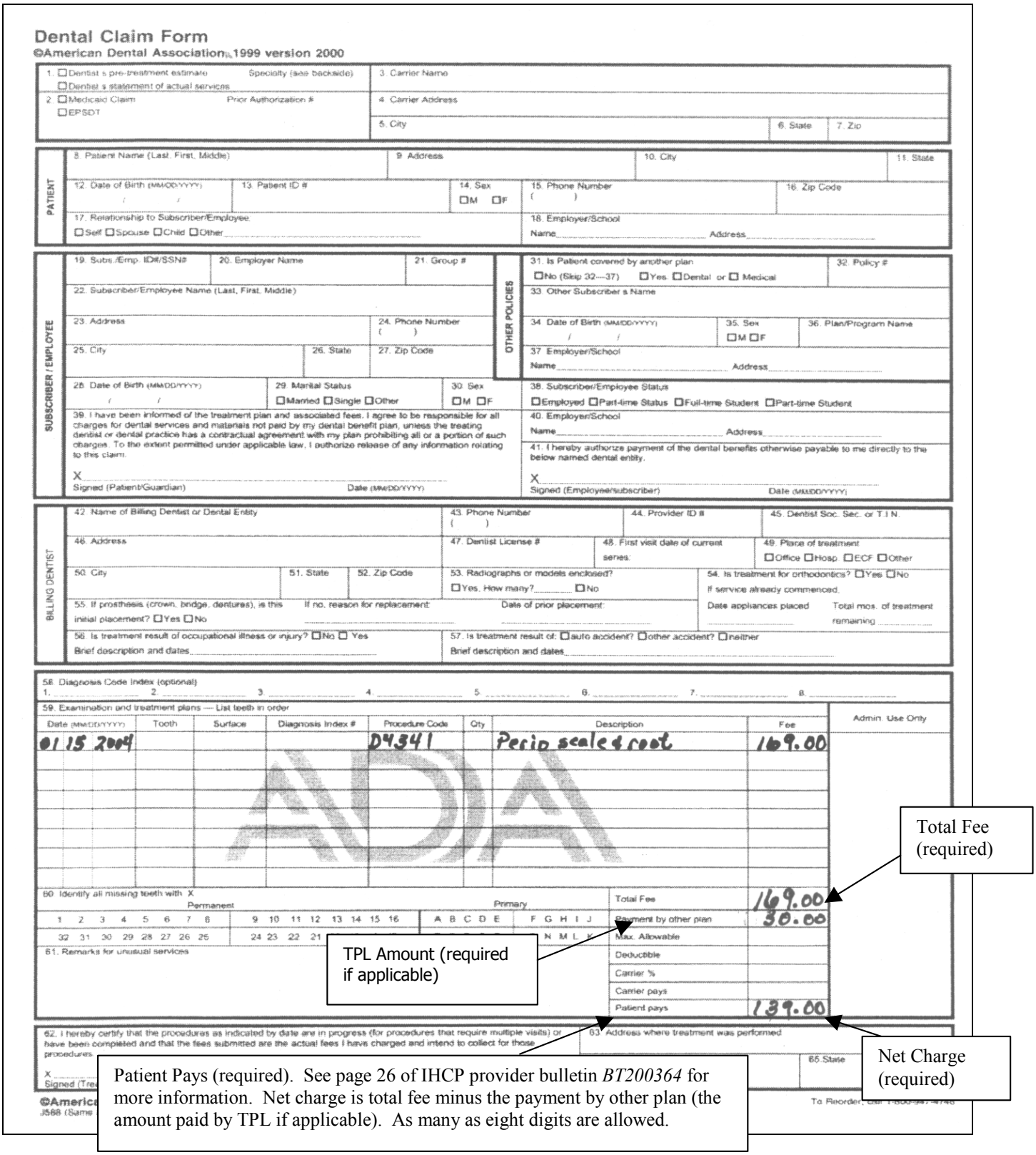

Figure 1 – Dental Claim Form

DME Services

Eligibility Verification

Effective June 1, 2004, the IHCP is implementing changes to the EVS. These changes include additional benefit limitation information about total dollars spent toward the $1950 annual rolling cap for incontinence supplies. DME providers obtain total amount paid toward this benefit limitation. This dollar is based on paid claims data. Claims not yet received or adjudicated are not reflected in the amount shown. When inquiring about the current status of spending for incontinence supplies, the system will include the 12 months prior to the date included in the eligibility inquiry and report the *Supply Dollars Spent*. When the $1950 cap amount is met for that rolling calendar time period, DME providers will see the *Benefit Exceeded* note for this service.

AVR and Web interChange will be updated automatically with no provider action required. OMNI users wishing to use the new benefit limitation information must download new OMNI software that includes these updates. Providers using other software packages for eligibility verification must contact their software vendors to ensure that the new software is being used. Table 10 lists DME benefit limitations effective June 1, 2004.

Table 10 – Benefit Limitations Effective June 1, 2004

Provider Type	Service Type Code	Benefit Limitation Information
DME	18	$2000 annual limit
DME	12	$5000 lifetime limit
DME	42	$1950 rolling 12 month cap

Coding and Criteria for Coverage of Humidifiers for use with CPAP (E0561 and E0562)

The IHCP recently adopted two new HCPCS codes for non-heated and heated humidifiers based on the 2004 HCPCS update. Effective January 1, 2004, the non-heated humidifier, code K0268, was changed to E0561 and heated humidifier, code K0531, was changed to E0562. HCPCS code E0561 is reimbursed at a max fee of $107 and E0562 is reimbursed at a max fee of $301.22.

The IHCP also adopted a revised humidifier policy based on research indicating that these humidifiers are single patient-use items that cannot be resold after initial use. This policy is effective May 15, 2004. The revised policy is as follows:

- Humidifiers E0561 and E0562 for use with a non-invasive respiratory assistive device (RAD) will be considered for coverage only when physician documentation supports the medical necessity of the humidifier. Documentation must indicate that the member is suffering from nosebleeds, extreme dryness of the upper airways, or other conditions that interfere with compliance or use of the RAD, and that the humidifier could improve this condition.
- A non-heated (E0561) or a heated (E0562) humidifier will be covered for use with a RAD (codes E0601, K0532, and K0533), when ordered by a physician, based on medical necessity, subject to prior authorization.
- E0561 and E0562 are inexpensive and routinely purchased items available for purchase only. They are single-patient use items. A rental trial is no longer required before purchase of non-heated or heated humidifiers.

Direct questions about this policy to the HCE Medical Policy Department at (317) 347-4500.

Vision Services

Vision Billing Requirements

This article informs vision providers about new billing requirements for rose 1 and rose 2 tints. The 2004 annual HCPCS update deleted codes for rose 1 and rose 2 tints (V2740, V2741, V2742, and V2743). These codes were replaced with a single code, V2745, *Addition to lens, tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens*.

According to *405 IAC 5-23-4 (2*), the IHCP may only reimburse for tints 1 and 2, as previously represented by V2740 and V2742. The new code, V2745, includes tints other that those reimbursable by the IHCP and will remain non-covered. To reimburse providers for rose 1 and rose 2 tints, the IHCP has added procedure modifiers to V2745. Table 11 lists changes effective April 1, 2004.

Table 11 – Vision Billing Requirements

Code and Modifier	Description	Code replaced
V2745 U1	Tint, plastic, rose 1 or 2, per lens	Replaces V2740
V2745 U2	Tint, glass, rose 1 or 2, per lens	Replaces V2742

IHCP Provider Field Consultants Effective March 12, 2004

Territory Number	Provider Representative	Telephone	Counties Served
1	Randy Miller (temp)	(317) 488-5388	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, and Starke
2	Debbie Williams	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, and Whitley
3	Chris Kern	(317) 488-5326	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, and White
4	Randy Miller	(317) 488-5388	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, and Wells
5	Relia Manns	(317) 488-5187	Marion
6	Tina King	(317) 488-5123	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, and Washington
7	Phyllis Salyers	(317) 488-5148	Clay, Greene, Johnson, Hendricks, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, and Vigo
8	Pam Martin	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, and Warrick
9	Pat Duncan (temp)	(317) 488-5101	Out-of-State

Field Representatives for Bordering States

State	City	Representative	Telephone
Illinois	Chicago/ Watseka	Pat Duncan (temp)	(317) 488-5101
	Danville	Chris Kern	(317) 488-5326
Kentucky	Louisville/Owensboro	Pam Martin	(317) 488-5153
Michigan	Sturgis	Debbie Williams	(317) 488-5080
Ohio	Cincinnati/Hamilton/Harrison/Oxford	Tina King	(317) 488-5123

Out-of-state providers not located in these states, or those with a designated out-of-state billing office supporting multiple provider sites throughout Indiana should direct calls to (317) 488-5139.

Statewide Special Program Field Representatives

Special Program	Representative	Telephone
590	Laura Merkel (temp)	(317) 488-5356
Dental	Pat Duncan	(317) 488-5101
Waiver	Mona Green	(317) 488-5152

Client Services Department Leaders

Title	Name	Telephone
Director	Darryl Wells	(317) 488-5013
Supervisor	Connie Pitner	(317) 488-5154

Note: For a map of provider representative territories or for updated information about the provider field representatives, visit the IHCP Web site at www.indianamedicaid.com.

Indiana Health Coverage Programs Quick Reference Effective April 15, 2004

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization		Pharmacy Benefits Manager
EDS Customer Assistance (317) 655-3240 1-800-577-1278	**EDS Forms Requests** P.O. Box 7263 Indianapolis, IN 46207-7263	**Indiana Drug Utilization Review Board** INXIXDURQuestions@acs-inc.com
EDS Member Hotline (317) 713-9627 1-800-457-4584	**Indiana Health Coverage Programs Web Site** www.indianamedicaid.com	**ACS PBM Call Center for Pharmacy Services/POS/ProDUR** 1-866-645-8344 Indiana.ProviderRelations@acs-inc.com
EDS OMNI Help Desk 1-800-284-3548	**HCE Prior Authorization Department** P.O. Box 531520 Indianapolis, IN 46253-1520 (317) 347-4511 1-800-457-4518	**ACS Preferred Drug List Clinical Call Center** 1-866-879-0106
EDS Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263		**PA For ProDUR and Indiana Rational Drug Program – ACS Clinical Call Center** 1-866-879-0106 fax 1-866-780-2198
AVR System (317) 692-0819 1-800-738-6770	**HCE Medical Policy Department** P.O. Box 53380 Indianapolis, IN 46253-0380 (317) 347-4500	**Indiana Pharmacy Claims/Adjustments** c/o ACS P. O. Box 502327 Atlanta, GA 31150
EDS Electronic Solutions Help Desk (317) 488-5160 1-877-877-5182 INXIXElectronicSolution@eds.com	**HCE Provider and Member Concern Line (Fraud and Abuse)** (317) 347-4527 1-800-457-4515	**Indiana Administrative Review/Pharmacy Claims** c/o ACS P.O. Box 502327 Atlanta, GA 31150
EDS Provider Enrollment/Waiver P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	**HCE SUR Department** P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 1-800-457-4515	**Drug Rebate** ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332
EDS Third Party Liability (TPL) (317) 488-5046 1-800-457-4510 Fax (317) 488-5217	**EDS Administrative Review** Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	**To make refunds to IHCP for pharmacy claims send check to:** ACS State Healthcare – Indiana P.O. Box 201376 Dallas, TX 75320-1376

Hoosier Healthwise (Managed Care Organizations and PCCM) and *Medicaid Select*				
Harmony Health Plan www.harmonyhmi.com **Claims** 1-800-504-2766 **Member Services** 1-800-608-8158; TTY: 1-877-650-0952 **Prior Authorization/Medical Management** 1-800-504-2766 **Provider Services** 1-800-504-2766 **Pharmacy** 1-800-608-8158	**MDwise** www.mdwise.org **Claims** 1-800-356-1204 or (317) 630-2831 **Member Services** 1-800-356-1204 or (317) 630-2831 **Prior Authorization/Medical Management** 1-800-356-1204 or (317) 630-2831 **Provider Services** 1-800-356-1204 or (317) 630-2831 **Pharmacy** (317) 630-2831 1-800-356-1204	**Managed Health Services (MHS)** www.managedhealthservices.com **Claims** 1-800-414-9475 **Member Services** 1-800-414-5946 **Prior Authorization/Medical Management** 1-800-464-0991 **Provider Services** 1-800-414-9475 **Nursewise** 1-800-414-5946 **ScripSolutions (PBM)** 1-800-555-8513	**Prime*Step* (PCCM)** www.healthcareforhoosiers.com **Claims - EDS Customer Assistance** 1-800-577-1278 or (317) 655-3240 **Member Services** 1-800-889-9949, Option 1 **Prior Authorization** HCE: 1-800-457-4518 or (317) 347-4511 **Provider Services for PMPs** 1-800-889-9949, Option 3 Pharmacy – see ACS in Pharmacy Benefit Manager section above	***Medicaid Select*** www.medicaidselect.com **Claims - EDS Customer Assistance** 1-800-577-1278 or (317) 655-3240 **Member Services** 1-877-633-7353, Option 1 **Prior Authorization** HCE: 1-800-457-4518 or (317) 347-4511 **Provider Services for PMPs** 1-877-633-7353, Option 3 Pharmacy – see ACS in Pharmacy Benefit Manager section above

Claim Filing				
EDS 590 Program Claims P.O. Box 7270 Indianapolis, IN 46207-7270	**EDS Adjustments** P.O. Box 7265 Indianapolis, IN 46207-7265	**EDS CCFs** P.O. Box 7266 Indianapolis, IN 46207-7266	**EDS Dental Claims** P.O. Box 7268 Indianapolis, IN 46207-7268	**EDS CMS-1500 Claims** P.O. Box 7269 Indianapolis, IN 46207-7269
Claim Attachments P.O. Box 7259 Indianapolis, IN 46207-7259	**EDS Waiver Programs Claims** P.O. Box 7269 Indianapolis, IN 46207-7269	**EDS Medical Crossover Claims** P.O. Box 7267 Indianapolis, IN 46207-7267	**EDS Institutional Crossover/UB-92 Inpatient Hospital, Home Health, Outpatient, and Nursing Home Claims** P.O. Box 7271 Indianapolis, IN 46207-7271	

Check Submission (non-pharmacy)		
To make refunds to IHCP: **EDS Refunds** P.O. Box 2303, Dept. 130 Indianapolis, IN 46206-2303	**To Return Uncashed IHCP Checks:** **EDS Finance Department** 950 N. Meridian St., Suite 1150 Indianapolis, IN 46204-4288	

Indiana Health Coverage Programs

PROVIDER WORKSHOP REGISTRATION

Please **print** or **type** the information below and fax to (317) 488-5376.

Medicaid 201

Please indicate the workshop you will be attending in Indiana:

☐ Kokomo, April 20, 2004	☐ Muncie, April 27, 2004	☐ Merrillville, May 18, 2004
☐ South Bend, May 25, 2004	☐ Indianapolis, June 3, 2004	☐ Evansville, June 16, 2004
☐ Bloomington, June 17, 2004	☐ Columbus, June 22, 2004	☐ Fort Wayne, June 24, 2004

Medicaid and Managed Care Roundtable

Please indicate the workshop you will be attending in Indiana:

☐ Kokomo, April 20, 2004	☐ Muncie, April 27, 2004	☐ Merrillville, May 18, 2004
☐ South Bend, May 25, 2004	☐ Indianapolis, June 3, 2004	☐ Evansville, June 16, 2004
☐ Bloomington, June 17, 2004	☐ Columbus, June 22, 2004	☐ Fort Wayne, June 24, 2004

The Adjustment Process

Please indicate the workshop you will be attending in Indiana:

☐ Kokomo, April 20, 2004	☐ Muncie, April 27, 2004	☐ Merrillville, May 18, 2004
☐ South Bend, May 25, 2004	☐ Indianapolis, June 3, 2004	☐ Evansville, June 16, 2004
☐ Bloomington, June 17, 2004	☐ Columbus, June 22, 2004	☐ Fort Wayne, June 24, 2004

Hospice

Please indicate the workshop you will be attending in Indiana:

☐ Kokomo, April 20, 2004	☐ Muncie, April 27, 2004	☐ Merrillville, May 18, 2004
☐ South Bend, May 25, 2004	☐ Indianapolis, June 3, 2004	☐ Evansville, June 16, 2004
☐ Bloomington, June 17, 2004	☐ Columbus, June 22, 2004	☐ Fort Wayne, June 24, 2004

Registrant Information

Name of Registrant: _____

Provider Number: _____

Provider Name: _____

Provider Address: _____

City: _____ State: _____ ZIP: _____

Provider Telephone: _____ Provider Fax: _____

Provider E-Mail Address: _____