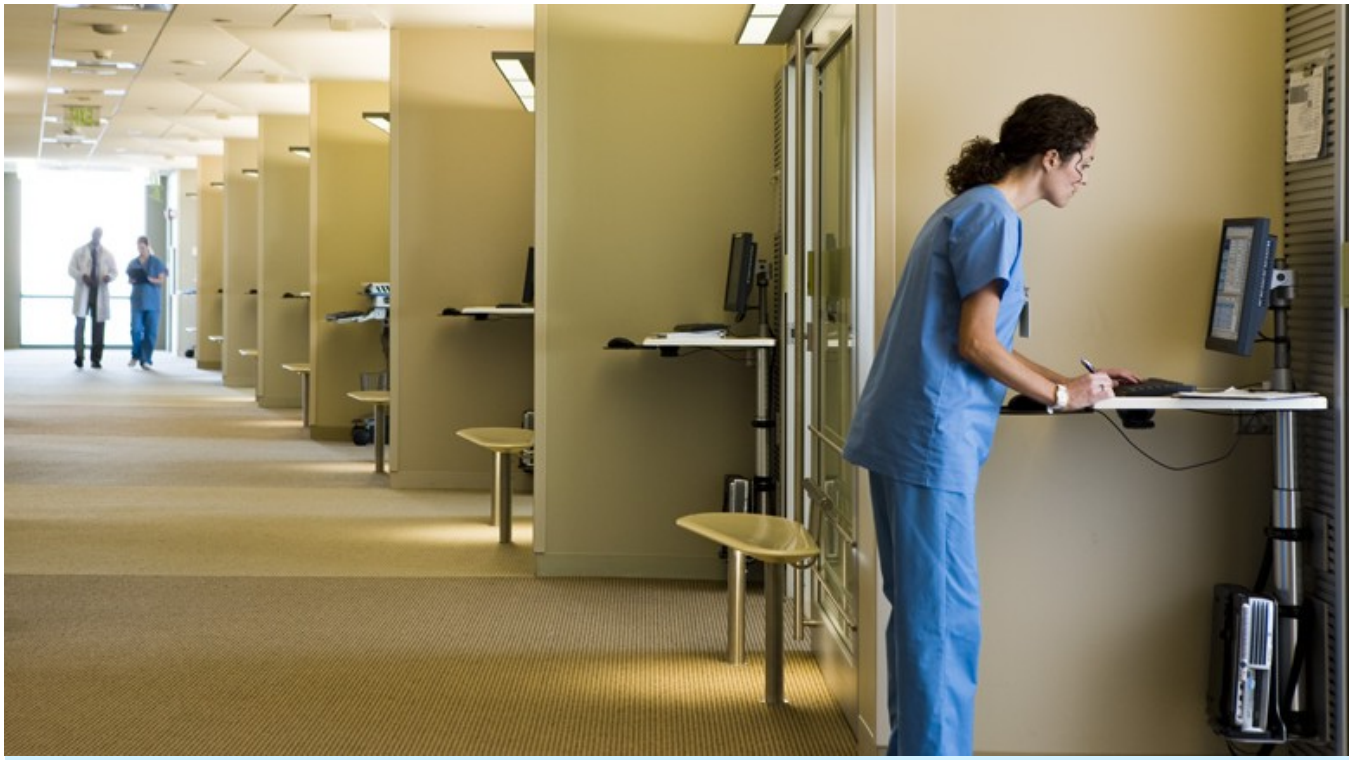
PROVIDER *news*

INDIANA HEALTH COVERAGE PROGRAMS NL201101 JANUARY 2011



Doing business with Medicaid

NU/RR modifiers will only be used for CMS-1500 crossover claims

For claims with a date of service on or after January 1, 2011, a change in billing methodology for Healthcare Common Procedure Coding System (HCPCS) procedure codes E0607 and E0607 U1 – *Home blood glucose monitor* or A4253 and A4253 U1 – *Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips* will be implemented. (For more information, see BT201055, dated November 30, 2010.) The modifiers NU (indicating a new product) and RR (indicating a rental product) will only be used when billing CMS-1500 crossover claims. These modifiers (NU and RR) will not be required on other types of claims for these products. CMS-1500 crossover claims with dates of service on or after January 1, 2011, which contain either of these modifiers, will not be denied.

Continue

INSIDE STORIES

- MDS 3.0 training
- UB-04 claims
- HIPAA 5010
- Bitewing radiographs
- First-quarter provider workshops
- Omni downloads
- PA tips

Use the following telephone numbers for product assistance. Please note that the telephone number for Roche Diagnostics has changed since the original publication.

Telephone numbers for product assistance – diabetic test supplies

Manufacturer	Care Products Support Line
Abbott Diabetes Care	1-888-522-5226
Roche Diagnostics	1-888-803-8934

LTC providers: Plan to attend MDS 3.0 virtual training

- Will down-staging be required with MDS 3.0?
- Does the BIMS Interview for MDS 3.0 stand alone?
- Are there changes to the nursing restorative with MDS 3.0?

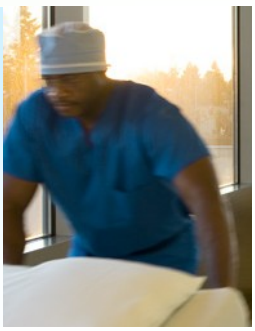
You'll hear the answers to these questions and many more at HP Enterprise Services' virtual training on Minimum Data Set (MDS) 3.0 case mix audit review and the new Supportive Documentation Guidelines (SDGs). The training will be January 12, 2011, from 2 p.m. to 3:30 p.m. (Indianapolis time) and will be presented via the HP Virtual Room (Web site) combined with a conference phone number. Preregistration is not required.

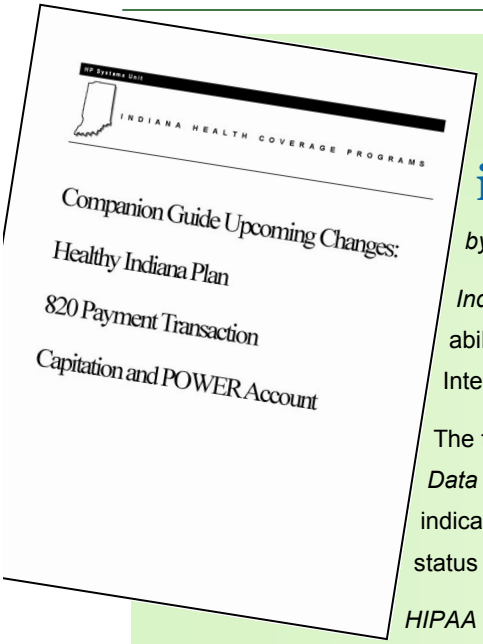
If you're an MDS coordinator or consultant, long-term care (LTC) administrator, social service employee, or other LTC facility team member responsible for completion or oversight of the MDS input, this seminar is for you. For a preview of the seminar, check out the PowerPoint file of the seminar posted on indianamedicaid.com. You may also sign up for the seminar online.

Claim reminder

To make claims processing faster and easier, please note that the correct way to submit payments on UB-04 claims in fields 50-55 is:

- A – Medicare – 54a
- B – Third-Party Liability, including Medicare Replacement Plans – 54b
- C – Medicaid – 55c





HIPAA 5010 Companion Guides and *Upcoming Changes* available on indianamedicaid.com

by EDI Solutions Analyst Marcia Reed

Indiana Health Coverage Programs (IHCP) Companion Guides for the Health Insurance Portability and Accountability Act (HIPAA) 5010 upgrades are available on the Electronic Data Interchange page of indianamedicaid.com.

The format of the *HIPAA 5010 Companion Guides* is similar to that of the *National Electronic Data Interchange Transaction Set Implementation Guides (IGs)*. IHCP Notes are included to indicate information specific to the IHCP. The IHCP *HIPAA 5010 Companion Guides* are in draft status to allow for modifications throughout the testing period of January through December 2011.

HIPAA 5010 Upcoming Changes documents are also available online. The Upcoming Changes documents, which have been available since November 2010, outline the changes to the X12 transactions that will be implemented by the IHCP for version 5010. The Upcoming Changes documents contain only the specific segments that are being added, deleted, or changed from the current HIPAA 4010 production Companion Guides.

5010 testing readiness surveys have been submitted to all software vendors and clearinghouses that exchange data with the IHCP. Providers should communicate with their software vendor, clearinghouse, or billing service to make sure these entities are scheduling a testing time with the IHCP. For answers to your questions, see the HIPAA 5010/NCPDP D.0 FAQs posted on indianamedicaid.com. Other resources include INXIXTradingPartner@hp.com and the Electronic Solutions Service Desk at 1-877-877-5182 or (317) 488-5160.

To speed dental claims, bill bitewing radiographs on separate claims

by Provider Relations Representative Daryl Davidson

Providers may have noticed delays in receiving reimbursement when bitewing radiographs are reported on claims. Dental providers were informed in BR201039 that claims including bitewing radiographs suspend for utilization auditing and require additional processing time. To avoid this delay in payment, providers may bill bitewing radiograph codes on a separate claim from other patient services performed that same day. By billing the radiograph codes separately, providers ensure faster payment for the other services furnished. Bitewing radiograph codes will continue to suspend for utilization auditing, in accordance with the guidelines stated in *405 IAC 5-14-3(2)*.

Sign up now for first-quarter IHCP workshops

The Indiana Health Coverage Programs (IHCP) is once again offering educational workshops to providers free of charge. First-quarter offerings include:

IHCP Updates – Presented by HP, this session provides information about important changes in the Medicaid program, including:

■ Transition and testing for ANSI version 5010 ■ Changes to the dental cap ■ Changes to therapy and vision services ■ Diabetic test supplies ■ Updated Healthcare Common Procedure Coding System (HCPCS) codes for 2011 ■ Prior authorization guidelines for inpatient hospital stays ■ The new standardized prior authorization form ■ The National Correct Coding Initiative (NCCI) ■ Rate changes for transportation, chiropractic, and waiver attendant care services ■ Software download for Omni users

Life of a Claim – Have you wondered how your claims are processed? This session breaks down the steps that have an impact on all claims submitted to HP. You will learn how prior authorization, system edits and audits, pricing, and medical policy suspensions affect the way claims are processed. But it doesn't end there – the session also discusses ways to correct your claims through online adjustments. This presentation is ideal for those who are new to Medicaid.

Prior Authorization – This session, which demonstrates how to complete a prior authorization request online using Web interChange, is appropriate for doctors of medicine and osteopathy, dentistry, optometry, and podiatry, as well as chiropractic providers, outpatient mental health providers, and employees of home health agencies and hospitals.

Care Select *2011 Overview* – Presented by representatives from ADVANTAGE Health Solutions[SM] and MDwise, this session provides an overview of the redesigned *Care Select* program, including *Care Select*'s change in scope, its new program goals, primary medical provider (PMP) enrollment process, and disease management for specific chronic conditions.

Anthem Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW) Updates – Representatives from the Anthem HIP and HHW plans are excited to present helpful information for providers. The useful tools and materials you receive during this session will bring you up to date with the latest changes for 2011, including information such as claims filing, prior authorization, PMP responsibilities, and more. Anthem strives to address your needs and ease administrative burdens related to HIP and HHW by providing ongoing education for you and your staff. HP encourages you and your staff members who work with Anthem HIP and HHW to attend this session.

MDwise Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW) Updates – This session for all providers covers the upcoming changes to HHW and the HIP for our MDwise providers and members. The tools and materials you receive during this session will bring you up to date with new forms, prior authorization, claims filing, new program (managed

care entity) rules, and information you need to know for your members. The session also provides information on the 2011 Health Plan Employer Data and Information Set (HEDIS) measures that include MDwise-specific targets for HHW and HIP. The session focuses on how to increase quality of care and appropriate billing in each performance measure, and how these topics relate to performance ratings, interventions, and pay-for-performance initiatives. This session also focuses on the importance of HEDIS, National Committee for Quality Assurance (NCQA), and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services as they relate to MDwise and your provider office. You will receive tools and resources to help promote increased performance in 2011.

MHS – Your Family Health Plan and Cenpatico Behavioral Health 2011 Updates for HHW and the HIP – Representatives from each entity will cover important updates for 2011, including information regarding MHS – Your Family Health Plan, HIP, HHW, and Cenpatico Behavioral Health.

For information about workshop dates, locations, and registration, visit indianaimedicaid.com.

Omni download required for correct PMP information

With the reprocurement of Hoosier Healthwise (HHW) and the Healthy Indiana Plan (HIP), effective January 1, 2011, the managed care entity (MCE) is now responsible for assigning its respective members to primary medical providers (PMPs). This change requires that Omni users perform downloads to their Omni machines to obtain the correct PMP information when checking eligibility via the Omni machine. Instructions for downloading can be found in Table 1.1 in IHCP bulletin BT200711 or in Table 3.7 in *Chapter 3*, *Section 5* of the *IHCP Provider Manual*. The download takes approximately 15 minutes. If you don't perform the download, the information returned on the Omni machine doesn't reflect complete PMP information if a PMP has not been assigned. You may still refer to Web interChange for accurate and complete information.

What will change on the Omni response after the download to my Omni machine?

If the member has an MCE assignment but not a PMP assignment on the date of service being verified, the OMNI returns the MCE name and phone number with a status of "PMP not assigned yet." If the member has both an MCE and a PMP assignment on the date of service being verified, the Omni returns the MCE name and telephone number plus the PMP name and phone number. Members may see any IHCP-enrolled provider when there is no PMP assignment.

If a member does not yet have a PMP assignment, the MCE is still responsible for paying claims for services covered under managed care (RBMC) or HIP. Providers should contact the MCE to confirm that there is no PMP assignment and to obtain billing guidelines. HP will continue to pay for services carved out of managed care.

If you have questions, please call the Omni help desk at (317) 488-5051 in the Indianapolis local area or toll-free at 1-800-284-3548.

Helpful hints for PA

Here are some helpful hints to make prior authorization (PA) go more smoothly:

- Remember to verify member eligibility to ensure that the PA request is submitted to the correct vendor for review. PA requests sent to the wrong vendor are rejected.
- PA requests and documentation that have been faxed multiple times are often illegible when received. HP recommends that providers also submit an unsigned clear copy of the request for review marked "for clarity only." The clarity document does not require a signature.
- The decision date printed on the prior authorization (PA) notification letter for nonpharmacy PAs is the date the PA was originally entered into the PA database, not the date the decision was rendered. For example, a PA is received and entered into the system June 1; however, a decision is not rendered until June 8. The decision date included on the letter is June 1, the date the PA is entered into the system.

RECENTLY PUBLISHED TO THE IHCP WEB SITE

BULLETINS

- *BT201057* – Reduction in Transportation Reimbursement
- *BT201058* – Therapy Services Limitations
- *BT201059* – Revision: Dental Cap Increased to $1,000
- BT201060 – Revision: New Prior Authorization for Elective Hospital Inpatient Admission

IHCP PROVIDER MANUAL

The following chapters of the *IHCP Provider Manual* have been updated:

- *Chapter 3 – Electronic Solutions*

LOOKING FOR MORE INFORMATION ABOUT PROVIDER MANUAL UPDATES?

- Subscribe to IHCP E-mail Notifications.
- The Revision History at the front of each section of the *IHCP Provider Manual* provides more detailed information about each revision.

NEWS FROM RECENT BANNER PAGES

- Coverage for Ophthalmologic Uses of HCPCS Code J3300
- Contact Information for PDSL Assistance
- Reimbursement Reduction Not Reflected on IHCP Fee Schedule
- Updated Pricing for Procedure Codes Previously Manually Priced
- Cozaar and Hyzaar Claims
- Omni Download Required
- 2011 HCPC Updates Are Available

FOR MORE INFORMATION

- Contact your Provider Relations Field Consultant
- IHCP Provider Quick Reference – a complete list of addresses, telephone numbers, and fax numbers for the IHCP and IHCP vendors