PROVIDER *news*

INDIANA HEALTH COVERAGE PROGRAMS NL201203 MARCH 2012

INSIDE STORIES

Doing business with Medicaid

Providers and vendors cite need in ICD-10 surveys for training

Plan now to respond to the next provider readiness survey in May

The need for training in the International Classification of Diseases, Tenth Edition (ICD-10), has moved to the top of the list of providers' and vendors' needs, as cited by respondents to the recent ICD-10 IHCP Provider Readiness Survey and the ICD-10 Vendor Readiness Survey. Reports of limited progress, barriers to implementation, and specific requests for additional assistance have led to plans to add an ICD-10 Training page to the ICD-10 information on indianamedicaid.com.

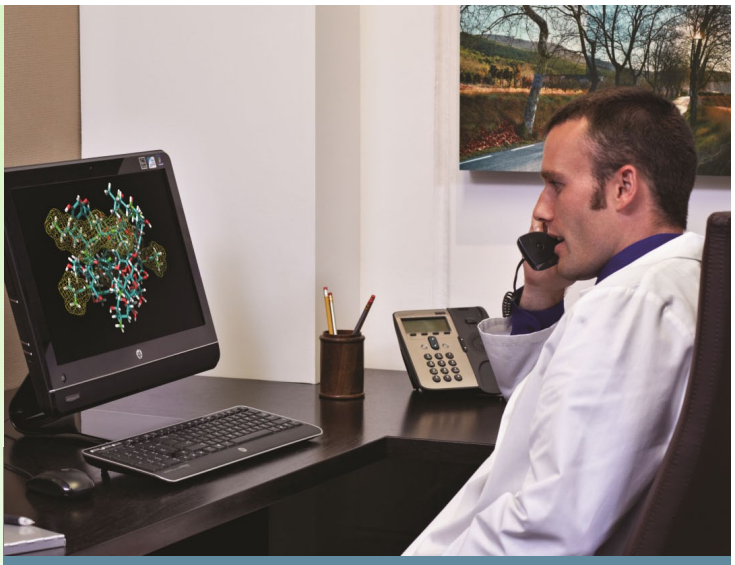
Continue

"To date, survey response rates have lowered with each release. To effectively address the breadth of training needs and other issues, we need to hear from as many entities as possible throughout the implementation period."

Affected vendors and Indiana Health Coverage Programs (IHCP) providers are invited to complete ICD-10 Readiness Surveys at regular intervals to track progress toward implementation. To date, survey response rates have lowered with each release. To effectively address the breadth of training needs and other issues, we need to hear from as many entities as possible throughout the implementation period.

- The next ICD-10 Vendor Readiness Survey is scheduled to release Monday, May 7, 2012. Invitations and surveys will be sent to affected vendors.
- The next ICD-10 IHCP Provider Readiness Survey will be posted to the indianamedicaid.com provider home page Tuesday, May 8, 2012.

Plan now to take a few minutes to respond to the May survey.



Intent to delay ICD-10 compliance date

The U.S. Department of Health and Human Services (HHS) recently issued an announcement of the intent to delay the ICD-10 compliance date:

HHS News, February 16, 2012. HHS Announces Intent to Delay ICD-10 Compliance Date

You can find the IHCP's response to the HHS announcement under News and Announcements on the home page of indianamedicaid.com.

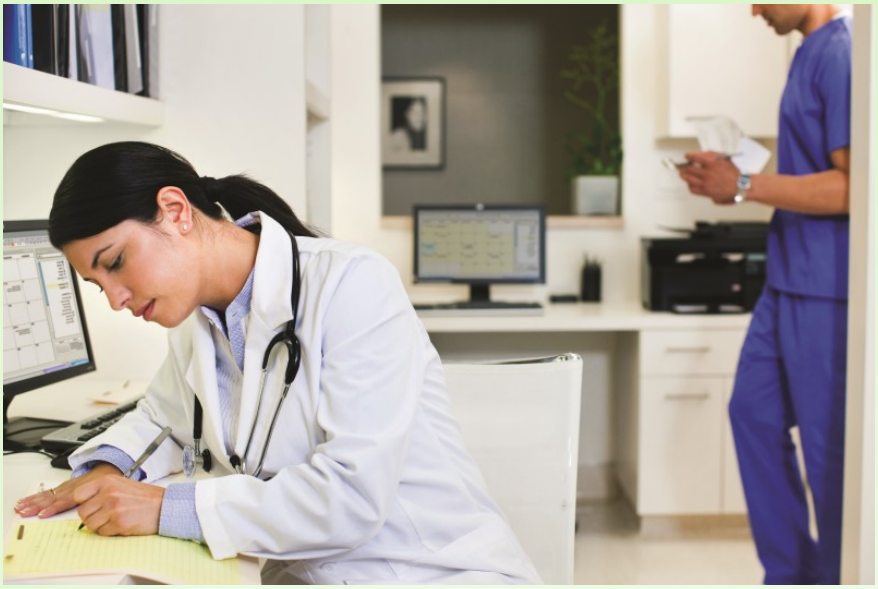
Long-term care news

- **Revision of MDS 3.0 Supportive Documentation Guidelines** – The long-term care (LTC) stakeholder's workgroup is revising the Minimum Data Set (MDS) 3.0 Supportive Documentation Guidelines (SDGs). When the guidelines are finalized, the SDGs will be located on the MDS 3.0 page of indianamedicaid.com (Provider-Specific Information > Long Term Care > MDS 3.0). Watch for more information.
- **HP Summary Report of LTC Facilities Reviewed** – The 2011 LTC Annual Report and the most recent LTC monthly audit report (January 2012) are available for download on the Monthly Summary Report of LTC Facilities Reviewed web page on indianamedicaid.com (Provider-Specific Information > Long Term Care). The reports contain audit validation rates, analyses by risk category, summaries of monthly statistics for all facilities reviewed, and more.

IHCP-covered services excluded from Hoosier Healthwise

Scenarios that require members' disenrollment from RBMC

Several situations, resulting from a change in health status, require that an Indiana Health Coverage Programs (IHCP) member be disenrolled from the Hoosier Healthwise risk-based managed care (RBMC) program. These situations include members who are transitioning to a long-term care facility, a psychiatric residential treatment facility (PRTF), hospice care, a waiver program, or to the 590 Program. In most cases, a level-of-care designation is required to trigger disenrollment from RBMC. Until the Hoosier Healthwise disenrollment occurs, fee-for-service (FFS) claims (except for carved-out services) for these members will deny. Therefore, it is important to be proactive and use the following disenrollment processes.



Long-term institutional care

Hoosier Healthwise members requiring long-term care in a nursing facility or intermediate care facility for the mentally retarded (ICF/MR) must be disenrolled from RBMC. Before the facility can be reimbursed for FFS claims, members must be disenrolled from the managed care entity (MCE) with which they are enrolled.

- The nursing facility or ICF/MR must request a Pre-Admission Screening Resident Review (PASRR) for facility placement. The facility should initiate the PASRR in advance of admission and before submitting claims. The facility also must notify the member's MCE of the request within 72 hours.
  - If the facility fails to verify an IHCP member's coverage or fails to contact the MCE within 72 hours of admission, the provider is responsible for any charges incurred until the member is disenrolled from the MCE.
  - If the facility fails to complete the paperwork for the appropriate level of care determination, and the member is still enrolled in Hoosier Healthwise after two months, the MCE is no longer liable for payment. However, as long as the patient remains a member of the MCE, FFS claims will be denied payment.
  - An MCE may obtain services for its members in a nursing facility on a short-term basis, such as fewer than 30 days. Short-term stays in nursing facilities are more cost-effective than other options, and the member can obtain the care and services needed from the nursing facility. The MCE can negotiate rates for reimbursing the nursing facilities for these short-term stays.
  - It is possible for a member's PASRR process to be under way (but not complete) while the member is linked to an MCE. In this situation, the financial responsibility lies with the MCE for no more than 60 days.
- The State approves the PASRR request and designates the appropriate level of care in Indiana*AIM*.

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- A level of care automatically triggers RBMC disenrollment and is processed the same date as the processing date of the level of care.
- More detail is available in the *IHCP Hospice Provider Manual* and *Chapter 14* of the *IHCP Provider Manual*.

Psychiatric residential treatment facility services

Hoosier Healthwise members receiving treatment in a PRTF must be disenrolled from RBMC. Before the facility can be reimbursed for FFS claims, members must be disenrolled from the managed care entity (MCE) with which they are enrolled.

- The PRTF provider must submit a PRTF prior authorization (PA) request for the member to the prior authorization vendor, ADVANTAGE Health Solutions℠. The fax number is 1-800-689-2759. The PRTF facility must also contact the MCE with which the member is enrolled before the member is admitted to the PRTF, or immediately on admission to the PRTF, if advance notice is not possible.

- ADVANTAGE approves the PA request as appropriate and enters the PRTF level of care in Indiana*AIM*.
- A PRTF level of care code automatically triggers RBMC disenrollment and is processed the same date ADVANTAGE enters the level of care. Therefore, the disenrollment date and the level of care date are the same.
- The PRTF must notify ADVANTAGE when the member is discharged.
- ADVANTAGE end-dates the level of care for the member.
- Once the level of care is end-dated, and if the member is still eligible for RBMC, the auto-assignment process immediately reassigns the member to his or her previous MCE with an effective date of the first or the 15th of the month, depending on when the member was disenrolled from the PRTF.
- More detail is available in *Chapter 6* of the *IHCP Provider Manual*.

Hospice care

Hospice care is not covered under Hoosier Healthwise; however, terminally ill members may qualify for hospice care under the FFS Medicaid program once they are disenrolled from RBMC.

- Hospice providers must submit a hospice election form for the member via fax to ADVANTAGE. The fax number is 1-800-689-2759. The hospice facility must also contact the MCE in which the member is enrolled.
- ADVANTAGE approves the request as appropriate and designates the appropriate hospice level of care in Indiana*AIM*.
- A level of care segment automatically triggers RBMC disenrollment and is processed the same date as the processing date of the level of care. RBMC disenrollment documentation is faxed to a dedicated fax number – (317) 810-4488.
- The MCE must coordinate care for its members who are transitioning into hospice, including providing the IHCP

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hospice provider with any information required to complete the hospice election form. More detail is available in the *IHCP Hospice Provider Manual* and *Chapter 6* of the *IHCP Provider Manual*.

Home and Community-Based Waiver Services

Home and Community-Based Waiver Services (HCBS) are excluded from Hoosier Healthwise. Members who have been approved for these waivers must be disenrolled from RBMC. The MCE must coordinate care for its members who are transitioning to an HCBS waiver program until the disenrollment is effective.

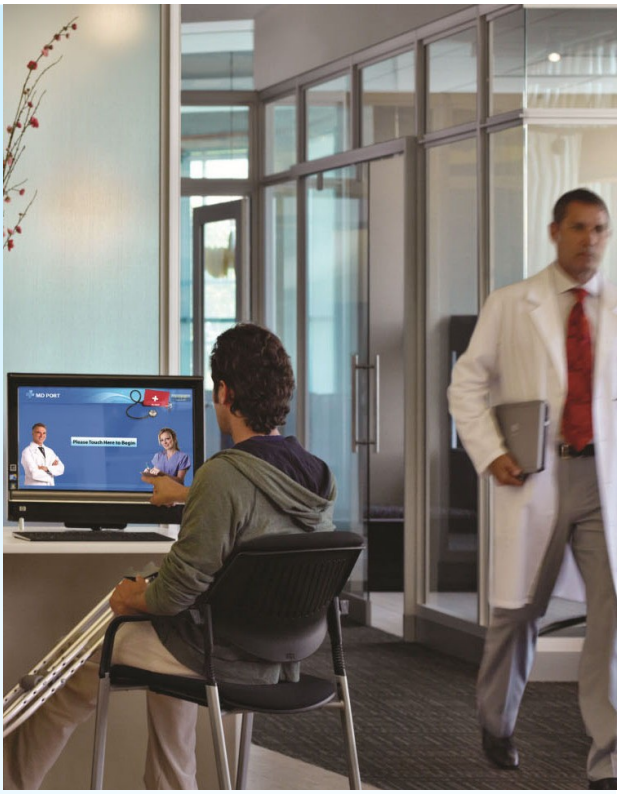
- The member's waiver case manager submits a Notice of Action to the appropriate state agency to request waiver designation. The Division of Disability and Rehabilitative Services (DDRS) processes applications for autism, developmental disabilities, and support services waivers. The Division of Aging (DA) processes applications for aged and disabled and traumatic brain injury waivers. Refer to the *HCBS Waiver Provider Manual* for specific locations and contact information.
- The appropriate state agency reviews the waiver designation request and enters a waiver level of care into Indiana*AIM*.
- Indiana*AIM* systematically disenrolls the member from RBMC, effective the date the level of care was processed. If a retroactive level of care date is entered, the member will still be disenrolled from RBMC as of the "processing date."
- The MCE must coordinate care for its members who are transitioning into the HCBS waiver program by providing the IHCP waiver provider with any required information. More detail is available in the *HCBS Waiver Provider Manual* and *Chapter 14* of the *IHCP Provider Manual*.

Medicaid-to-590 Program disenrollment

Hoosier Healthwise members being transitioned to the 590 Program must be disenrolled from RBMC.

- The State-operated facility must send a request to the county caseworker of the Division of Family Resources Service Center requesting that Medicaid be suspended for the member. Most of these members are on disability Medicaid and not in Hoosier Healthwise.
- The State-operated facility faxes State form *32696 E/D/T (Enrollment/Discharge/Transfer)* to the HP Eligibility Unit to enroll the member in the 590 Program. The fax number is (317) 488-5217.
- The HP Eligibility Unit enters the 590 enrollment for the member and faxes the completed form back to the State-operated facility. The 590 enrollment automatically triggers RBMC disenrollment, both effective the same date.
- More detail is available in the *590 Program Provider Manual* on indianamediciaid.com.

HIPAA 5010 final countdown



As of February 28, 2012, 83% of all Indiana Health Coverage Programs (IHCP) trading partners had successfully converted to *Health Insurance Portability and Accountability Act* (HIPAA) version 5010. Beginning March 31, 2012, all electronic data interchange (EDI) transactions must be 5010 compliant. This includes:

- Incoming claims – 837I, 837P, 837D
- Eligibility Inquiry and Response – 270/271
- Claim Status Request and Response – 276/277
- Electronic Remittance Advice – 835

Trading partners that have not yet converted to 5010 must:

- Submit a request to continue submitting claims in version 4010A.
- Verify that your software vendor has completed testing for HIPAA 5010.
- Submit an updated Trading Partner Profile.
- Submit an updated Trading Partner Agreement.

After the IHCP receives your Trading Partner Profile and Agreement, you will be converted to HIPAA 5010. If you have questions, contact the EDI Solutions team at INXIXTradingPartner@hp.com.

IHCP providers still submitting NCPDP 5.1 claims

CMS grace period ends March 31

If you have not transitioned to National Council for Prescription Drug Programs (NCPDP) D.0, do it now! All providers must have transitioned to NCPDP D.0 by March 31, 2012. Seventy Indiana Health Coverage Programs (IHCP) providers were still submitting claims in version 5.1 format as of February 24, 2012.

Please see the updated payer sheet on indianamedicaid.com (General Provider Services > Electronic Data Interchange (EDI) Solutions > Companion Guides) for more information; and see NL201111 for specific billing instructions. If you have questions, email INXIXPharmacyD0@hp.com.

Concurrent hospice and curative care services for children

The *Affordable Care Act* (ACA) requires that hospice services be provided to children without the children forgoing any other service to which they are entitled under Medicaid for treatment of a terminal condition. The Indiana Health Coverage Programs (IHCP) now covers all medically necessary curative treatment for terminally ill children, 20 years of age and under, concurrently with hospice care, for dates of service on or after March 23, 2010. As a result, hospice forms on the Forms page of indianamedicaid.com have been updated:

- The Medicaid Hospice Plan of Care for Curative Care – Members 20 Years and Younger form is a new form that allows providers to include care information related to the curative services.
- Medicaid Hospice Election form – The election statement section of this form has been updated to include language related to receiving concurrent services up to the age of 21.

Provider education

There's still time to sign up for March provider workshops

The March 28 workshop in Evansville will now be conducted via HP Virtual Room, making it easy to "attend"! With Virtual Room training, you can follow the presentation on your computer while listening to the presenter by telephone.

It's not too late to sign up for on-site seminars, as well – March 13 in Bloomington; March 21 in Indianapolis; and March 27 in Lafayette. For more information and to register, visit the Provider Education page of indianamedicaid.com.

RECENTLY PUBLISHED TO THE IHCP WEB SITE

BULLETINS

- BT201205 – Concurrent Hospice and Curative Care Services for Children
- BT201206 – The IHCP to Allow Birthing Centers to Enroll as Medicaid Providers
- BT201207 – The IHCP to Allow CORFs and IDTFs to Enroll as Medicaid Providers

PROVIDER MANUAL UPDATES

IHCP Provider Manual – the following chapters of the manual have been updated:

- *Chapter 1* – *General Information*
- *Chapter 9* – *IHCP Pharmacy Services Benefit*
- *Chapter 11* – *Paid Claim Adjustment Procedures*
- *Chapter 12* – *Financial Services*
- *Chapter 14* – *Long-Term Care*

590 Program Provider Manual

Healthwatch/EPSDT

Medicaid Rehabilitation Option (MRO) Provider Manual

LOOKING FOR MORE INFORMATION ABOUT PROVIDER MANUAL UPDATES?

- Subscribe to IHCP E-mail Notifications.
- The Revision History at the front of each manual (or chapter) provides detailed information about the updates made in the most recent revision.

RECENT BANNER PAGES ARTICLES

- CPT Code 64405 Linked to Modifier 50
- CPT Code 17111 Linked to Revenue Code 490 and New ASC Rate Added
- The IHCP's First-Quarter Workshops
- We Want Your Feedback about ICD-10
- How to Document MSRP for Manually Priced DME and Medical Supply Items
- We Want Your Feedback about ICD-10
- Sign Up Now for the IHCP's First-Quarter Workshops
- New Reimbursement for Rental of Continuous Passive Motion Exercise Device (for Use Other Than Knee)
- CPT Codes 37765 and 49422 Linked to Revenue Code 490
- IHCP First-Quarter Workshops Continue Through March
- How to Submit Claims for Implantable Cardioverter Defibrillator Devices
- Update to MHQAC Edits

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