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To All Providers:

- With the implementation of Electronic Voids and Replacements (EVR), it is important that providers adhere to all filing limits guidelines. If the date of service on a replacement claim is beyond the one year filing limit, providers should submit the replacement via paper to the EDS Adjustment Unit with the appropriate documentation to avoid inadvertent recoupment of the entire claim paid amount.

  The Indiana Health Coverage Programs (IHCP) policy on filing limits indicates that claims must be submitted within a year from the date of service (DOS). Prior to the implementation of EVR, claims submitted past the filing limit were reviewed by a claims resolution clerk. If the DOS was over a year old and no documentation was submitted with the claim, the claim was rejected and no adjustment made.

  With the implementation of EVR, providers may void a claim electronically without regard to the one-year filing limitation. However, if a replacement claim is submitted and the DOS is past the one year limit, the claim suspends for filing limit edits. Providers receive a claim correction form (CCF) status and are asked to provide documentation to support waiving the filing limit. If the documentation is not received within 45 days of the CCF, the claim will deny for all services instead of being rejected as in the previous process.

  A system modification to reject claims over the year filing limit is currently being completed. Until this system modification is implemented, providers who want to make adjustments to claims over one year old must either provide the documentation when the claim CCFs or submit the replacement claim on paper. Failure to take one of these actions will result in the entire payment for that claim being recovered by the program. Further instructions will be given to providers when the system modification is complete.

To Ancillary and Medical Services Providers:

- Effective **August 2, 2005**, all providers that anticipate performing, or that perform, ancillary and medical services to Medicaid members during an inpatient stay at a State Hospital should contact the State Hospital to receive reimbursement. When patients who are enrolled in Medicaid receive services at a State Hospital, the State Hospital is responsible for all of the ancillary and medical costs incurred during the Medicaid member's stay. The IHCP will deny any claim requesting reimbursement for ancillary treatment and all medical services while the Medicaid member is an inpatient at the State Hospital.

To All Dental Providers:

- This notification reminds providers of the requirements for completing the *American Dental Association (ADA) 2000 Dental Claim Form*. Please pay special attention to the fields, **Total Fee**, **Payment by other plan**, and **Patient pays.**

  The **Total Fee** field must be completed for all claims and should indicate the total of all individual service line charges.

  – The **Payment by other plan** field must be completed to reflect third party liability (TPL) payments only.

– The **Patient pays** field must be completed only on claims for which a TPL payment has been received. This field indicates the net charge. Failure to indicate a net charge in the **Patient pays** field will result in a claim denial with the explanation of benefits (EOB) *401 – Net charge is missing*.

For claims that **do not** include a third party liability (TPL) payment, providers are not required to complete the "Payment by other plan" field or the "Patient pays" field.

To All Durable Medical Equipment Providers:

- Currently, providers bill both adjustable and nonadjustable seat cushions using the same Healthcare Common Procedural Coding System (HCPCS) codes. Adjustable cushions have all of the characteristics of a skin protection seat cushion (E2603 and E2604) or skin protection and positioning seat cushion (E2607 and E2608); however, they are also adjustable. Adjustments are made by adding or removing significant quantities of air, liquid, gel, or other fluid medium in physiologically appropriate areas of the cushion to promote pressure reduction.

  New, more descriptive procedure code and modifier combinations (PICS) have been developed for billing adjustable seat cushions. Medicare currently utilizes four definitions for adjustable seat cushions, each billed with procedure code K0108. The IHCP has mirrored this policy by creating four PICS with unique definitions for each type of adjustable seat cushion. The new coding and pricing information for adjustable seat cushions is listed in **Table 1** and will be effective September 30, 2005. The coding and fee schedule for all other wheelchair seat cushions will remain the same.

Table 1 – Adjustable Seat Cushion Codes Effective September 30, 2005

Code	Description	Pricing
K0108 U1 NU	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches	$330.81
K0108 U2 NU	Skin protection wheelchair seat cushion, adjustable, width greater than or equal to 22 inches	$389.54
K0108 U3 NU	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches	$378.68
K0108 U4 NU	Skin protection and positioning wheelchair seat cushion, adjustable, greater than or equal to 22 inches	$435.56

Adjustable cushions are purchase-only items. Providers must attach the NU modifier when billing adjustable seat cushions. The adjustable cushions do not have to be listed on the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) classification list in order to be reimbursed by the IHCP.

Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To All Nursing Facility and Hospice Providers:

- The IHCP has begun making retro rate adjustments to nursing home rates for the nursing facility quality assessment fee in late July 2005. The purpose of this article is to explain the quality assessment fee and the impacts for hospice providers. The change in nursing facility rates due to the quality assessment fee will result in retro rate adjustments for room and board to hospice providers retroactive to July 1, 2003. Therefore, hospice and nursing home providers are reminded that all coordination and payment arrangements regarding room and board under the hospice benefit should already be reflected in the hospice contract with the nursing facility.

  The nursing facility quality assessment is a result of *P.L. 224-2003* enacted by the 2003 Session of the Indiana General Assembly. *P.L. 224-2003* specifies that the Office of Medicaid Policy and Planning (OMPP) shall collect a quality assessment fee from nursing facilities, and those funds are used in part to increase nursing facility reimbursement. Based on the approval that the OMPP received from the Centers for Medicare and Medicaid Services (CMS), these changes are effective retroactive to July 1, 2003. Over the next few months, the nursing homes enrolled in the IHCP will receive revised rate

notices for all rate effective dates covering the periods of July 1, 2003, to the present. The revised rates contained in these notices will supersede the previously established rate for the corresponding time period. After all of the rates for prior periods have been recalculated using the new methodology, current and future rates will be reviewed and processed as usual. Any hospice claims that reflect room and board payment as billed under hospice revenue codes 653, 654, 659, 183, and 185 for service dates July 1, 2003, to present will be included in this retro rate adjustment for the quality assessment fee and will be subject to the payment parameters for the hospice benefit.

Federal regulations under *OBRA 89* and state regulations at *405 IAC 1-16-4* require Indiana Medicaid to pay the hospice directly any nursing facility room and board payments for service dates the member was under hospice care; and then the hospice pays the nursing home according to their contract. The hospice room and board adjustments for the nursing facility quality assessment will be handled no differently than any other Medicaid payment or adjustment for room and board in which the IHCP pays the hospice 95 percent of the nursing home rate on file to the hospice and the hospice then pays the nursing home according to their contract. The Office of the Inspector General (OIG) has indicated that hospices may pay a nursing facility up to 100 percent of the nursing home daily rate without raising concerns about fraud or kickbacks. The quality assessment fee will result in an increase in the nursing facility rate and the hospice will need to pay the nursing home according to their contract.

For example, if hospice A has a contract with nursing home A to pay 100 percent of the nursing home rate on file, hospice A will need to honor that payment arrangement when the hospice claim is adjusted for the nursing home quality assessment. For example, assume that nursing home A's rate was originally $100.00, and the nursing facility quality assessment fee changed the rate to $120.00. When the hospice claim is adjusted through the retro rate process, the hospice room and board will pay at $114.00 (95 percent of the nursing home rate); however, hospice A will be required to pay nursing home A the $120.00 according to their contract.

To facilitate the payment of the nursing facility quality assessment fee retro rate adjustments, EDS plans to pull the hospice claims out of the retro rate cycle. The hospice claims adjustments will be processed through a mass claims adjustment. The nursing facility retro rates will be processed within a 12-week cycle. The hospice mass claims adjustments will be processed following the 12-week nursing facility retro rate cycles, which is estimated to begin in mid-October. Hospice providers will be able to identify the mass claims adjustments as a result of the nursing facility quality assessment by noting that their remittance advice will have an internal control number (ICN) starting with the number 56. Hospice mass claims adjustments with an ICN starting with 56 are to be distinguished from hospice retro rate adjustments starting with 55. Hospice providers are reminded that hospice mass claims adjustments are system-generated adjustments that do not require hospice providers to initiate a paper claims adjustment process. If EDS determines that there is a better process to expedite the retro rate adjustments for nursing facilities and hospices with regard to the nursing facility quality assessment, the IHCP will notify providers of this change by banner page.

If hospice or nursing facility providers have any questions regarding the reimbursement process for hospice room and board mass claims adjustments as a result of the nursing facility quality assessment, they may contact Michelle Stein-Ordonez of the OMPP at (317) 233-1956 or Karie Millard at Myers and Stauffer at (317) 846-9521. If a hospice has any questions regarding hospice retro rate adjustments starting with an ICN 55, or hospice mass claims due to nursing facility quality assessment starting with an ICN 56, the hospice provider may contact their EDS provider field consultant. Hospice providers may identify their EDS provider field consultant by viewing the August 2005 IHCP Newsletter at www.indianamedicaid.com.

To All Pharmacies and Prescribing Providers:

- Effective **October 7, 2005**, the following drug groups will be added to the State Maximum Allowable Cost (State MAC) for legend drugs rate list.

Drug Name	State MAC Rate
ACETYLCYSTEINE 10% VIAL	0.35530
AMPICILLIN TR 500 MG CAPSULE	0.15280
ACETIC ACID/ALUMINUM EAR DROPS	0.06990
DIAZEPAM 5MG/ML SYRINGE	0.95910
NEO/POLY/DEXAMET EYE OINT	0.57260
NIFEDIPINE 10 MG CAPSULE	0.16850
NYSTATIN 500,000 UNIT ORAL TAB	0.52600
TRAMADOL HCL-ACETAMINOPHEN TAB	0.76420

Effective **August 1, 2005,** State MAC rates for the following drugs have been increased as listed below.

Drug Name	State MAC Rate
ETHOSUXIMIDE 250 MG CAPSULE	0.82680
INDOMETHACIN 75 MG CAPSULE	1.77950

Please direct any questions about the State MAC for legend drugs to the Myers and Stauffer pharmacy unit by telephone at (317) 816-4136 or 1-800-591-1183, or by e-mail at pharmacy@mslc.com.

- A mass adjustment for pharmacy claims incorrectly adjudicated by ACS will be conducted during the week of September 10, 2005. These claims were associated with the State MAC program and were adjudicated between March 23, 2003 and June 2005. The affected claims included both underpayments and overpayments. Questions related to this mass adjustment should be directed to the ACS Pharmacy Services helpdesk at 1-866-645-8344 or via e-mail at Indiana.providerrelations@acs-inc.com.

  The mass adjustment amounts will be reflected in the weekly remittance advice (RA) and will be assigned to region 56. Providers who disagree with the adjustments may request an administrative review by writing to the following address:

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

  The request should include an explanation of the reason for disagreement and include copies of all pertinent supporting documentation. Refer to *Chapter 10, Section 6* of the *IHCP Provider Manual* for more information about the administrative review and appeal process.

- Effective January 1, 2006, the CMS is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.

  The IHCP Web site now includes a new section titled *Medicare Prescription Drug Coverage*. Providers should visit this section periodically at http://www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp for the latest information. The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare prescription drug benefit.

  For more information about the Medicare prescription drug benefit visit the CMS Web site at http://www.cms.gov/medicarereform/