B A N N E R P A G E

BR200550 DECEMBER 13, 2005

To All Providers:

- The purpose of this article is to remind providers of appropriate billing guidelines when submitting medical claims utilizing modifier 50, *bilateral procedure*, on the claim detail. The Indiana*AIM* system calculates the payment at 150 percent of the billed charge or the rate on file for the procedure code billed with modifier 50.

  Providers should note that if the CPT code description specifies the procedure as bilateral, modifier 50 should **not** be used on the claim detail. The units billed should be reflected as one (1) in field 24G of the claim submission. If the CPT code description does not specify the procedure as bilateral, then, modifier 50 should be used on the claim detail and the units billed should be reflected as a one (1). Providers submitting a claim with a bilateral procedure and multiple units should maintain supporting documentation in the member's medical record and payment of claims will be monitored on a post-payment review basis.

- This article provides clarification of information about "Denied Service Lines on Crossover Claims" that was published in the Indiana Health Coverage Program (IHCP) provider bulletin *BT200511* dated June 1, 2005. **Effective December 29, 2005**, the manner in which Medicare PART B crossover claims (Medical or Outpatient) are processed in the Indiana*AIM* system will be modified. When received in the 837 COB format, the Medicare denied service lines will be posted as denied service lines by the IHCP. This will eliminate the need for providers to adjust the claim.

  The purpose of this change is to assist providers in receiving payment for Medicare denied details in a timely manner. Currently the system will not allow payment of details that may have been denied by Medicare unless the provider first submits an adjustment to "reverse" the denied details. Effective with this change, providers may submit a "Medicaid-only" claim to receive payment for denied details, without first completing an adjustment.

  Providers may utilize the Web interChange to resubmit a claim, previously received electronically from Medicare, for consideration of the Medicare paid service lines. However, the provider must delete the denied service lines from the claim. If the detail(s) is not removed from the claim and a provider submits a detail that reflects a zero amount in the coinsurance, deductible, psych deductible, blood deductible, and Medicare paid amounts, providers will receive an error message that states, "Detail is considered a Medicare-denied detail and should not be included on the claim. Please add crossover information or delete the detail."

  To receive payment, providers must resubmit the Medicare Part B (Medical or Outpatient) denied detail(s) as a Medicaid fee-for-service claim. The Medicare Remittance Notice (MRN) must be submitted as an attachment to the claim for verification that the service(s) was denied by Medicare.

- This article informs IHCP providers of updates to the type of bill (TOB) codes that may be submitted to the IHCP program. **Effective December 29, 2005**, the IHCP is compliant with the UB92 editor TOB code set. However, not all codes are covered by the IHCP. If a claim with a valid TOB is submitted via Web interChange or an 837I transaction, but the TOB is not covered by the IHCP program, the claim will be adjudicated and denied with edit 594, *TOB is not covered by the IHCP*. If a claim is submitted via Web interChange with an invalid TOB, the provider will receive an error message that states, "Type of bill is not valid for this claim type." If a claim with an invalid TOB is submitted via the 837I transaction, the claim file will be rejected with error code 272, *invalid TOB.* This information will be reported to the provider or vendor on the Biller Summary Report (BSR). For a complete listing of error codes that are reported on a provider or vendor BSR and the complete listing of TOB codes, access the following links:

  Link for the listing of valid Type of Bill code set

  http://www.indianamedicaid.com/ihcp/Forms/Type_of_Bill_Table.pdf

Link for IHCP EDI reports & acknowledgements
http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/EDI_Reports.pdf

- The IHCP Web site now includes Ambulatory Surgical Center (ASC) assignment codes and pricing. The ASC assignment codes classify Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes to a payment group based on an estimate of the facility costs associated with performing the procedures. Providers may access this information on the IHCP Web site at www.indianamedicaid.com under *Fee Schedule*. The ASC listing contains assignment codes, effective dates, and pricing. Additionally, assignment codes relating to specific CPT and HCPCS codes are available on the IHCP Web site at www.indianamedicaid.com under *Fee Schedule* using the procedure code or description search feature.
- On November 1, 2005, the IHCP implemented the PA Web application, which allows providers to submit non-pharmacy PA requests and to inquire about requests using the Web interChange. Providers can continue submitting PA requests on paper or by telephone or fax and following existing policies when submitting PA requests. To inquire about existing PAs, providers must have a PA number or be the requesting or service provider of the PA. Doctors, dentists, home health agencies, hospices, optometrists, health service providers in psychology (HSPP), chiropractors, hospitals, and transportation providers may submit PA requests. Providers may obtain detailed information about using this new Web application from the IHCP Web site at www.indianamedicaid.com.

To All Anesthesia Providers:

- For the time period of October 15, 2003, through August 31, 2005, medical and Medicare Part B medical claims submitted for anesthesia services and billed with modifiers *QK, Medical direction of two, three, or four concurrent anesthesia service,* or *QX, CRNA service,* were inappropriately denied for edit *4014,no pricing segment on file.* Beginning the week of December 13, 2005, these claims are being voided and reprocessed and begin appearing on providers' remittance advice (RA) statements. The issue relating to adjudicated claims posting edit 4014 that had created underpayments has been corrected.

To All Hospice Providers:

- The IHCP completed a nursing home retro-rate adjustment for the nursing facility quality assessment fee. The IHCP began extracting the hospice claim information for this adjustment in October 2005. Claims were adjusted and appeared on November 8, 2005, RAs. Hospice providers can identify that the claims adjustments were a result of the nursing facility quality assessment by the internal control number (ICN) on their RA. These ICNs begin with the number 55 and have a Julian date between 304 and 306.

  For questions about the reimbursement process for hospice room and board adjustments that resulted from the nursing facility quality assessment, contact Michelle Stein-Ordonez at the OMPP at (317) 233-1956 or Karie Millard at Myers and Stauffer at (317) 846-9521.

- According to Section 3 of the *IHCP Hospice Programs Manual*, the IHCP may special batch hospice claims. When a claim is special batched, it appears on the hospice provider's RA with an ICN that begins with **90**.

  Some hospice claims with service dates that had been paid by special batch have been denied payment when they were adjusted during the hospice retro-rate adjustments. However, Indiana*AIM* was updated on July 14, 2005, and the mass claims adjustment process no longer provides a mechanism for an adjusted claim to suspend for edit 2024. An EDS claims clerk can view a paid claim to determine if it was previously forced. If a claim was not forced, the clerk forces the claim to ensure payment during a hospice claims retro-rate adjustment.

  Service dates paid through the special batch process prior to July 14, 2005, which have denied during retro-rate adjustments, must be corrected. To meet the criteria, the claim must have been a hospice claim with an ICN starting with 90, and a hospice retro-rate adjustment must have resulted in a denial of service dates that were previously on the original claim through the special batch process on their RA. Providers may contact Michelle Stein-Ordonez, Medicaid Policy Analyst, at (317) 233-1956 for case-specific questions or concerns. To correct a claim for a retro-rate adjustment, the hospice provider must fax a corrected and complete hospice claim for denied service dates to Michelle Stein-Ordonez at (317) 232-7382. Ms. Stein-Ordonez sends the claim to EDS with a special batch request to reprocess the original claim and the adjustment. Hospice providers should not have denied claims for service dates paid through the special batch claims process after July 14, 2005.

To All Pharmacies and Prescribing Providers:

- Effective **January 27, 2006,** 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
ALBUTEROL 5 MG/ML SOLUTION	0.22060
BUPROPION HCL SR 150 MG TABLET	1.37240
CEFTRIAXONE 1 GM VIAL	7.73220
OXYCODONE HCL ER 10 MG TABLET	0.97965
OXYCODONE HCL ER 20 MG TABLET	1.81377
OXYCODONE HCL ER 40 MG TABLET	3.31950
OXYCODONE HCL ER 80 MG TABLET	6.07032
PROCHLORPERAZINE 5 MG/ML VL	3.40200

Effective **December 13, 2005,** State MAC rates for the following drugs will be **increased** as listed below.

Drug Name	State MAC Rate
AMITRIPTYLINE HCL 10 MG TAB	0.030987
AMITRIPTYLINE HCL 150 MG TAB	0.132630
CIPROFLOXACIN HCL 500 MG TAB	0.134274
METHYLPHENIDATE 5 MG TABLET	0.216930
METOCLOPRAMIDE 5 MG/5 ML SOLN	0.009247
PEG 3350/ELECTROLYTE SOLN	0.005078

Effective **January 27, 2006,** State MAC rates for the following drugs will be **decreased** as listed below.

Drug Name	State MAC Rate
ALBUTEROL 0.83 MG/ML SOLUTION	0.04325
BACIT/POLYMYXIN EYE OINT	1.44914
CARBIDOPA/LEVO 25/100 TAB	0.18936
CARBIDOPA/LEVO 50/200 ER TAB	0.90687
CHLORHEXIDINE 0.12% ORAL RINSE	0.00559
CIPROFLOXACIN HCL 250 MG TAB	0.08106
CLARITHROMYCIN 500 MG TABLET	1.61062
CLINDAMYCIN HCL 150 MG CAP	0.17721
ESTRADIOL 1 MG TABLET	0.03337
FOLIC ACID 1 MG TABLET	0.03803
GABAPENTIN 600 MG TABLET	1.09383
HYDROCODONE/APAP 7.5/500 TB	0.05048

Drug Name	State MAC Rate
LISINOPRIL-HCTZ 20/12.5 TAB	0.12765
LITHIUM CARBONATE 300 MG CAP	0.06780
LORAZEPAM 2 MG TABLET	0.08205
METFORMIN HCL 850 MG TABLET	0.10937
NABUMETONE 750 MG TABLET	0.53536
POLYMYXIN B/TMP EYE DROPS	0.18900
TRAMADOL HCL-ACETAMINOPHEN TAB	0.68865
TRIAMCINOLONE 0.1% CREAM	0.02741
TRIAMTERENE/HCTZ 37.5/25 TB	0.04766
TRILYTE WITH FLAVOR PACKETS	0.00618

Effective **December 13, 2005,** State MAC rates for the following drugs will be **removed** as listed below.

Drug Name	State MAC Rate
ERYTHROMYCIN ST 500 MG CAPLT	0.16790
METHAMPHETAMINE HCL 5 MG TAB	1.54170
THEOPHYLLINE ER 400 MG TABLET	0.89520
THEOPHYLLINE ER 600 MG TABLET	1.36720

Direct any questions regarding the State MAC for legend drugs to the Myers and Stauffer pharmacy unit at (317) 816-4136 or 1-800-591-1183, or via email at pharmacy@mslc.com.

- 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 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.

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