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To All Providers:

- In an effort to benefit Indiana Health Coverage Programs (IHCP) providers, the IHCP delayed the June 22, 2005, implementation of the system modifications that would post the Medicare denied service lines as denied service lines. This updates information published in IHCP provider bulletin *BT200511, HIPAA Modifications*, June 1, 2005.

  This modification is being delayed because the IHCP does not currently receive Medicare electronic crossover claims in the 837 COB format. Therefore, the IHCP continues to adjudicate Medicare denied service lines and reflect a paid status. To remove the paid status from denied service lines, a provider should continue using the adjustment process before resubmitting claims as Medicaid fee-for-service claims.

  The IHCP is working with the Medicare intermediaries and carriers to obtain electronic Medicare Part B crossover claims in the 837 COB format to eliminate the need for providers to submit adjustments to previously adjudicated claims.

  When the IHCP begins processing electronic crossover claims in the 837 COB format, the IHCP will implement the system modifications necessary to post the Medicare denied service lines as denied service lines. Additional information about these system modifications will be published in future banner page articles or newsletter articles.
- Effective July 1, 2005, providers should submit Pre-Admission Screening and Resident Review (PASRR) and Medical Review Team (MRT) claims to EDS using the paper CMS-1500 claim form, the electronic 837 Professional Claims and Encounter (837P) Transaction format, or the electronic Web interChange claims submission application. The State will continue to process paper PASRR and MRT claims sent to the Office of Medicaid Policy and Planning (OMPP), if they are postmarked no later than June 10, 2005. If the OMPP receives claims postmarked after June 10, 2005, the claims will be returned to the provider. These claims must be sent to EDS for processing and payment using the new claims submission method. Providers should refer to IHCP provider bulletin *BT200513* for more information about submitting PASRR claims and IHCP provider bulletin *BT200514* for more information about submitting MRT claims.
- Effective May 23, 2005, the Restricted Card Program (RCP) has a new fax number. The new fax number is (317) 347-4550. Providers should use this new number to fax all referrals and other concerns for restricted members in Traditional Medicaid, *Medicaid Select*, and primary care case management (PCCM). Providers may direct questions about the RCP to Health Care Excel, Attention: Restricted Card Program, P.O. Box 531700, Indianapolis, IN 46253-1700, by telephone at (317) 347-4527 in the Indianapolis local area or 1-800-457-4515, or by fax at (317) 347-4550.

To All Dental Providers:

- During the week of June 6, 2005, the IHCP identified a high number of claim denials for edit *1008 – rendering provider must have an individual number*. This error occurs when a provider submits a billing group number in the detail line. Per IHCP provider bulletin *BT200511*, published June 1, 2005, all group providers must use their rendering provider numbers. To expedite claims, providers should follow these guidelines:
  - **Group provider using a paper claim** – Enter the group number and location code s in field 44A. Enter the *individual* rendering number s in the Administrative column adjacent to each detail submitted.
  - **Group provider using Web interChange** – Enter the group number and location code in the provider number field. Enter the *individual* rendering number in the rendering provider field.
  - **Individual billing provider using a paper claim** – Enter the individual billing number and location code in field 44A. Enter the individual billing number in the Administrative column adjacent to each detail submitted.
  - **Individual billing provider using Web interChange** – Enter the individual billing number and location code in the provider number field. Enter the individual billing number in the rendering provider field.

Providers who use Web interChange can view their provider profiles to access a list of the rendering providers linked to the group. Providers can also call the Provider Enrollment Helpline at 1-877-707-5750 to discuss any updates that need to be made to the provider group information.

To All Assertive Community Treatment Community Mental Health Centers:

- EDS mass adjusted all claims paid from June 2004 through May 2005 that contained procedure code *H0040 – ACT Services, per diem.* This adjustment was necessary to meet internal processing and reporting requirements and began appearing on the May 31, 2005, remittance advice (RA).
- Assertive Community Treatment (ACT) services claims that posted edit *4033 – the modifier used is not compatible with the procedure code billed*, and denied on RAs dated February 22, 2005, through May 3, 2005, were mass adjusted and reprocessed by EDS and began appearing on the May 17, 2005, RA. Also, the updated logic for procedure code H0040 HW identifies claims that exceed the one unit per day limit. Claims that previously paid and did not limit the service to one unit per day, per member were mass adjusted and began appearing on the May 31, 2005, RA.

To All Durable Medical Equipment Providers:

- This article provides clarification of IHCP's policy for prior authorization (PA) and reimbursement of universal headrest plates. Effective June 7, 2005, HCPCS code *E1028 – Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory,* must be used for PA and billing. Requests for approval of the universal headrest plate using HCPCS code *E1399 – Durable medical equipment, miscellaneous;* will deny for appropriate coding. Providers should submit their usual and customary charge using HCPCS code E1028.

  Reimbursement of the universal headrest plates are subject to the following PA criteria:
  - Universal headrest plates are covered when the initial headrest ordered for a new wheelchair does not meet the member's needs upon the first or subsequent fittings. The provider must document on the PA request, the brand name and model of the original headrest and include an explanation of why the headrest did not meet the member's needs. In addition, the provider must indicate the brand name and model of the subsequent headrest that will be used on the wheelchair.
  - Universal headrest plates are covered for a used wheelchair if the member's condition changes, and the wheelchair back are not pre-drilled for the headrest. The provider must provide documentation of the medical necessity for the headrest.
  - Replacement universal headrest plates are covered with documentation of an explanation for the replacement (for example, plate is damaged due to high tone or spasticity of the patient).

  Universal headrest plates are not covered for the initial headrest ordered for use on a new wheelchair. The wheelchair back should be pre-drilled to accommodate the headrest initially ordered with the wheelchair.

  Providers should direct questions to the Health Care Excel Medical Policy Department at (317) 347-4500.

To Home Health Providers:

- Home health rates for 2005 are finalized and are effective January 1, 2005. Mass claims adjustments for the new rates will begin appearing on the June 7, 2005, RA. The new rates are shown in the following table:

Service	Rate
Registered Nurse (RN) – 99600 TD	$30.82
Licensed Practical Nurse (LPN) – 99600 TE	$21.99
Home Health Aide – 99600	$15.10
Physical Therapy – G0151	$13.92 per 15 minute increments
Occupational Therapy – G0152	$13.01 per 15 minute increments
Speech Therapy – G0153	$15.15 per 15 minute increments
Overhead	$21.09