IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201749 DECEMBER 5, 2017

IHCP reminds providers of January 1 deadline to update rendering provider linkages

The Indiana Health Coverage Programs (IHCP) reminds providers that correct rendering/group provider linkages are essential to the proper adjudication of rendering provider claims. IHCP policy requires rendering providers to be linked to the specific locations where they render services for a group practice. Further, a rendering provider's services may not be billed for a service location to which he or she is not linked. **Group providers must ensure that the provider profile for each group location has the correct rendering providers linked with accurate effective and end dates.**

In *Banner Page* BR201731, the IHCP announced that denials for explanation of benefits (EOB) 1010 – *Rendering provider is not an eligible member of billing group or the group provider number is reported as rendering provider. Please verify provider and resubmit*, would be temporarily converted to a "post-and-pay" status through December 31, 2017. A "post-and-pay" status means the claim-processing system allows claims and claim details with this issue to pay, even though the EOB 1010 message continues to post on the Remittance Advice (RA). This conversion was made to allow providers time to submit enrollment updates to appropriately link rendering providers to group locations.

Providers are reminded that effective January 1, 2018, the EOB 1010 edit will revert to a denial status. Providers should review their RAs in detail, note any EOB 1010 messages, and update rendering providers in service location profiles as necessary. (*BR201731* summarizes the steps for completing this process in the Portal.) Providers are encouraged to submit updates as soon as possible to allow for processing before the January 1, 2018, deadline.

IHCP will mass reprocess dental claims that may have denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) dental claims processed from November 22, 2017, through November 28, 2017. Claims for Current Dental Terminology (CDT®[1]) codes processed during this time frame may have inappropriately denied with explanation of benefits (EOB) 4013 - *This procedure is not covered for this date of service*.

The claim-processing system has been corrected. Claims processed during the indicated time frame that previously denied for EOB 4013 will be mass reprocessed. Providers should begin to see the reprocessed claims on Remittance Advices (RAs) beginning December 12, 2017, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

MORE IN THIS ISSUE

As a result of the system issue, the dental fees on the *Professional Fee Schedule* at indianamedicaid.com were removed in error. This issue was corrected and the dental fees should now be available on the fee schedule.

Modifier AA – *Anesthesia services performed personally by anesthesiologist* linked to anesthesia CPT codes

Effective January 5, 2018, the Indiana Health Coverage Programs (IHCP) will link the modifier AA − *Anesthesia services performed personally by anesthesiologist*, to the following Current Procedural Terminology (CPT®[1]) codes:

- Anesthesia procedure codes 00100-01999
- Add-on code 99140 – *Anesthesia complicated by emergency conditions (specify) (List separately in addition to primary anesthesia procedure)*

This linkage will apply retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **February 13, 2017**. Note that use of the AA modifier is not required; it is considered informational and does not affect payment.

Beginning January 5, 2018, providers may submit FFS claims for anesthesia codes 00100-01999 and 99140 for DOS on or after February 13, 2017, with modifier AA, as appropriate. Providers may also resubmit claims for the affected anesthesia codes billed with the AA modifier for the DOS indicated that previously denied for explanation of benefit (EOB) 4033 – *The modifier used is not compatible with the procedure code billed. Please verify and resubmit.* Claims resubmitted beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

QUESTIONS?

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