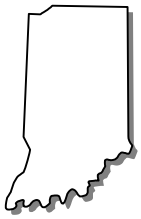

# IMPORTANT INFORMATION

BR200326 JULY 1, 2003

## To All Providers:

- Dental claims that were billed with procedure code D1201, and denied for audit 6211 will be mass adjusted and reprocessed. This mass adjustment should appear on the remittance advice (RA) dated July 8, 2003.
- The Indiana Health Coverage Programs (IHCP) recently published version 4.0 of the *IHCP Provider Manual*. The intent of this article is to correct the stated policy for neonatal transfers in Chapter 7, Section 2, pages 7 through 13, of this version of the manual. The new manual incorrectly states that the IHCP will reimburse the full diagnosis-related grouping (DRG) payment to transferring hospitals for all neonatal cases. However, *405 IAC 1-10.5-4 (w)* **does not** support payment of a full DRG on transfer cases unless the established DRG includes only transfer cases. Currently, a hospital that transfers a neonatal case automatically receives a full DRG rate when the claim groups to ***DRG 639*** *– Neonate, transferred less than five days old, born here,* or ***DRG 640*** *– Neonate, transferred less than five days old, not born here*. All other neonatal transfer claims will receive a DRG prorated daily rate for each day of hospitalization, not to exceed the full DRG amount. The *IHCP Provider Manual* will correctly state the reimbursement policy for transfer cases in future versions.
- The Health Insurance Portability and Accountability Act (HIPAA) provider workshops scheduled in Evansville, Ind. on July 22 and 23, 2003, have been moved to the following location:

  **Deaconess Hospital**
  **Deaconess Health Science Building**
  **Johnson Hall**
  **600 Edgar St.**
  **Evansville, IN 47710**

  The new site is adjacent to the previous location. Direct any questions to a provider representative at (317) 488-5195.
- This article reminds providers of the following items relating to HIPAA provider workshops occurring during June, July, and August 2003 described in provider bulletin *BT200328*:
  - Workshops are offered at no cost to providers
  - Workshops are not mandatory but are recommended
  - The HCFA-1500 claim form name change to the CMS-1500 claim form reflects the recent name change of the Health Care Financing Administration (HCFA) to the Centers for Medicare & Medicaid Services (CMS). Providers formerly billing with the HCFA-1500 claim form should attend workshops designed for the CMS-1500 claim form.
  - Workshop registrations are processed chronologically based on the workshop date. A letter or fax confirming registration will be sent prior to the workshop. Confirmations may be received as late as two days prior to the workshop.

  Please direct questions about workshops to a provider representative at (317) 488-5195.

## To All Pharmacy Providers, Durable Medical Equipment Suppliers, and Medical Suppliers:

IHCP provider bulletin *BT200338* published June 2, 2003, listed the Healthcare Common Procedure Coding Systems (HCPCS) code A6426 as manually priced. This code will be changed from manually priced to $1.08. This becomes effective August 14, 2003. Any questions should be directed to Ryan Farrell or Jared Duzan at Myers and Stauffer, LC, by telephone at (317) 846-9521 in the Indianapolis local area or toll free at 1-800-887-6927, or by e-mail at rfarrell@mslc.com and jduzan@mslc.com.

## To All Pharmacy Providers:

Third Party Liability (TPL) cost avoidance for **pharmacy claims billed on paper** continues to generate questions and concerns; therefore, the IHCP offers the following reiteration of the current policy as originally stated in IHCP provider bulletin *BT200221*, published May 15, 2002. Although the policy has been in place since July 1, 2002, the claims processing edits necessary to support the policy were not in place until implementation of the ACS claims processing computer system on March 23, 2003. For paper claims, when another insurance carrier is billed, but the carrier denies payment of the claim, the provider must submit documentation from the carrier acknowledging that the service was billed to the carrier, but the carrier denied payment of the claim. If the provider submits a claim to another insurance carrier and the carrier fails to respond, the provider must document this fact and submit this information along with the paper claim.

> *Note: Version 4.0 of the* IHCP Provider Manual, *published in April 2003, has not been updated to reflect all of the changes that have occurred as a result of implementation of the Pharmacy Benefit Manager, ACS.*