IMPORTANT INFORMATION

BR200402 JANUARY 13, 2004

To All Providers:

- On the remittance advices (RA) dated January 6, 2004, and January 13, 2004, claims billed with the appropriate modifiers denied for explanation of benefits (EOB) *4003 – Invalid procedure code modifier combination.* Impacted claims will be systematically reprocessed or adjusted and will appear in the RA dated January 27, 2004.
- Provider Electronic Solutions and National Electronic Claims Submission (NECS) software products are not HIPAA compliant. Providers that have continued to use these products have been given a 30-day notice. The final date for submission of claims using Provider Electronic Solutions or NECS is January 29, 2004. All Provider Electronic Solutions and NECS login identifications (IDs) will be disabled on January 30, 2004. Providers may use Web interChange, a clearinghouse, or an approved software vendor to submit claims. Further information about the submission of claims can be found at www.indianamedicaid.com .
- The Indiana Health Coverage Programs (IHCP) discovered an issue with the AP Diagnosis-related Group (DRG) Grouper Version 18, in regards to inpatient newborn services, causing the claims for babies 28-days old or younger to group to the wrong DRG and deny. Newborn claims billed with an admission date on or after November 1, 2003, through January 6, 2004, will systematically mass adjust or reprocess by January 20, 2004.
- Details on CMS-1500 paper claim forms processed between November 26, 2003, and December 24, 2003, may have adjudicated incorrectly. This issue primarily affects durable medical equipment (DME), anesthesia, therapy, and transportation claims. EDS will adjust claims that contained both paid and denied details. Claims in which all details denied should be resubmitted.
- Effective January 1, 2004, Customer Assistance will return to standard business hours. These hours are Monday through Friday 8 a.m. to 12 p.m. and 1 p.m. to 5 p.m. Contact the Customer Assistance Unit by calling (317) 655-3240 in the local Indianapolis area, or 1-800-577-1278.
- On January 1, 2004, the 2004 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) code updates will be loaded in Indiana*AIM*. Program coverage and pricing determination for the 2004 HCPCS and CPT codes will be finalized by April 1, 2004, and will be effective retroactively to January 1, 2004. Claims billed with 2004 HCPCS and CPT codes, prior to April 1, 2004, will be denied. Providers may continue to bill 2003 HCPCS and CPT codes prior to April 1, 2004. The 2004 HCPCS and CPT codes will be published in a future IHCP bulletin. This banner article does not affect the local code replacement activity scheduled to occur on January 1, 2004. Direct any questions to EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278.

To All Waiver Providers:

- Effective for dates of service January 1, 2004, replacement level I (CPT) or level II (national) codes must be used instead of local level III codes. Claims submitted with dates of service on or after January 1, 2004, with local codes and local code modifiers will deny.

To All Federally Qualified Health Centers and Rural Health Clinics:

- Effective December 30, 2003, the IHCP began a mass adjustment of all Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) service claims processed between April 1, 2003, and December 1, 2003, in order to correct the overpayment of the multiple details when claims were submitted after the Benefit Improvement and Protection Act of 2000 (BIPA) changes were implemented for those FQHC and RHC claims with the HCPCS procedure code T1015 and the CPTs for valid encounters.

To All Dental Providers:

- Effective December 17, 2001, dental providers that submit a claim for supernumerary teeth extractions must use procedure code *D7999 – Unspecified Oral Surgery Procedure, by Report*, and attach a note of explanation. A note of explanation is always required when billing D7999. The attachment should indicate the type of extraction performed and whether it is an erupted or impacted tooth. An impacted tooth must be documented as whether it is soft tissue, partially bony, or completely bony with any unusual complications listed.

  This is a manually priced code. Providers are required to bill their usual and customary fee. Claims without an attachment will be denied for explanation of benefits (EOB) *4019 – Attachment required for services rendered.* Tooth numbers should not be used on the claim form.