IMPORTANT INFORMATION

BR200403 JANUARY 20, 2004

To All Providers:

- Effective February 16, 2004, ACS will administer all prior authorization (PA) for the Indiana Health Coverage Programs (IHCP) pharmacy benefits program. Non-drug related PAs will continue to be administered by Health Care Excel (HCE). All PAs for drugs and Drug Utilization Review (DUR) edits will be administered by the ACS clinical call center at 1-866-879-0106.

  This information pertains only to fee-for-service drug PAs. This information does not affect members or providers rendering services to members in risk-based managed care (RBMC).

  ACS will continue to accept faxed requests for all PAs and preferred drug list (PDL) proton pump inhibitors, but will not accept faxed PDL authorization requests. The ACS clinical call center fax number is 1-866-780-2198.

  The ACS clinical call center is also extending its hours. The extended hours are 8 a.m. to 8 p.m., Monday through Friday, except federal holidays. The emergency supply feature, as outlined in the *IHCP Provider Manual*, Chapter 9, should be used when the ACS clinical call center is closed.

  Direct questions to the ACS PA help desk at 1-866-879-0106, or access the IHCP Web site at www.indianamedicaid.com.

- The purpose of this article is to serve as formal notification that a mass adjustment will occur to recoup overpayments for crossover A and C claims submitted by the Web *inter*Change on December 31, 2003, January 1, 2004, and January 2, 2004. These claims were adjudicated with the decimal point in the co-insurance amount, deductible amount, and blood deductible amount fields incorrectly causing an overpayment to providers. The adjustments will begin posting on remittance advice (RA), dated March 2, 2004.

- Medical claims on remittance advices (RA) dated January 6, 2004, and January 13, 2004, that have posted explanation of benefits (EOB) *4033-Invalid procedure code and modifier combination* may have adjudicated incorrectly, creating underpayments or overpayments. Processing for claims that have denied inappropriately will begin the week of January 27, 2004. Mass adjustment processing for overpaid claims will begin March 2, 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.
- On January 1, 2004, the 2004 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) code updates have been 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 Hospital Care for the Indigent Providers:

- A hospital-specific remittance will be added to the January 27, 2004, claim payment total as indicated in a letter from Myers and Stauffer LC dated December 23, 2003, to qualifying acute care hospitals. This hospital-specific payment amount for state fiscal year ending June 30, 2003, is listed on the Financial Transaction page of the remittance advice (RA), and is included in the total check amount for the week. This payment is not claim specific for either Medicaid or Hospital Care for the Indigent (HCI) claim activity. Please refer to bulletin *BT199930,* published October 29, 1999*,* for more information on the HCI program.

  The HCI program for SFY 2004 and thereafter, has changed and now requires qualifying acute care hospitals to submit HCI claims in order to receive the additional Medicaid add-on payment.

  Direct any questions concerning these issues to Michael Rusbasan or Melenie Burns at (317) 846-9521 in the Indianapolis local area, or 1-800-877-6927.

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.