I M P O R T A N T I N F O R M A T I O N

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To All Providers:

- Currently, the Indiana Health Coverage Programs (IHCP) limits the reimbursement of joint injections to three injections per joint site, per provider, per month. As standard courses of treatment may require more frequent injections, the IHCP has modified the policy to allow up to four injections per joint site, per provider, per month as medically necessary effective April 1, 2003. Claims submitted for more than four joint injections for the same member in a one month period must have supporting documentation attached to indicate that the injections involve different joint sites and that no more than four injections were administered to a single joint. The following CPT codes are affected by this change in policy.

Code	Description
20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

Providers may resubmit previously denied claims with supporting documentation for the fourth joint injection per joint site, per provider, per month. For claims that are past the one year filing limit a copy of this banner page may be utilized as supporting documentation to waive the filing limit. Providers may direct questions about this article to customer assistance at (317) 655-3240 in the Indianapolis local area or toll free at 1-800-577-1278.

To All Outpatient Hospitals and Ambulatory Surgery Centers:

- Upon implementation of the new outpatient reimbursement policy as stated in IHCP Provider Bulletin, *BT200420*, published September 15, 2004. The IHCP discovered a payment issue with regard to outpatient surgeries. When only one surgery or one unit of service was billed the system calculated the rate at 150 percent instead of 100 percent resulting in overpayments. Outpatient claims with paid dates between October 5, 2004, through November 9, 2004, were impacted. Therefore, the IHCP will initiate a systematic mass adjustment for all affected claims. Providers can expect adjusted claims to appear on the remittance advice (RA) statement dated March 8, 2005.

To Hospice and Nursing Facilities Providers:

- The IHCP has a change order in place for Indiana*AIM*, Indiana Medicaid's claims processing system that will expedite the adjustment of hospice claims for room and board under the IHCP hospice benefit. A change order is a request to modify Indiana*AIM* to accommodate changes to prior authorization (PA) or claims payment procedures. The purpose of this banner page is to provide an update on the status of this change order.

  The nursing facility retro rate adjustment process currently adjusts nursing facility claims when a rate change occurs during the quarters beginning January 1, April 1, July 1, and October 1 of the calendar year. This process does not currently look for hospice claims billed under bill type 822, hospice revenue codes 653, 654, 659, 183, and 185. The modification change order would permit Indiana*AIM* to identify hospice claims with the previously mentioned hospice revenue codes to mass claims adjust similar to the nursing facility claims. The IHCP had estimated that this change order would be completed by December 29, 2004; however, this date is not feasible due to the complexity of the system changes. Providers are asked to look for further notification about this change order in upcoming IHCP banner pages and IHCP newsletter articles.