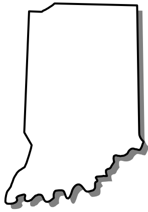

BANNER PAGE

BR200801 JANUARY 3, 2008

All Providers

Effective Date for Reporting National Drug Code Information on Institutional Outpatient Claims Extended to July 1, 2008

The Federal Deficit Reduction Act of 2005 mandates that all State Medicaid programs, including Indiana Health Coverage Programs (IHCP) require the submission of National Drug Code (NDC) information on claims submitted with certain procedure codes for physician-administered drugs. This mandate affects all providers who submit claims for procedure-coded drugs via Web interChange, electronic 837I, and the UB-04 paper claim form. Because the State may pay up to the 20 percent Medicare B co-payment for dual-eligible individuals, the NDC is also required on Medicare crossover claims for all applicable procedure codes.

The reporting of NDC information on outpatient and outpatient crossover claims was scheduled to begin January 1, 2008. The State has been granted a six-month extension of the effective date by the Centers for Medicare & Medicaid Services (CMS). The new effective date will be July 1, 2008.

Please contact your vendor to make the necessary software changes. Providers must be compliant by July 1, 2008.

> *Note: The IHCP policy is outlined in BT200713 and BT200731, including specific requirement and submission details. Additional information regarding this policy may be located under the claim information in the IHCP newsletter NL200708. As a reference guide, providers can access the Palmetto GBA Web site at http://www.palmettogba.com/. This Web site is in the public domain and furnishes an NDC crosswalk table, which relates procedure codes, NDCs, and NDC quantity conversion. Providers should utilize this tool as a guide to conversions but should not rely on it as a sole source for NDC quantity information. Providers must also remember that it is imperative that the NDC listed on the claim is representative of the actual product NDC administered to the member by the healthcare provider. Providers must continue to monitor the IHCP Web site for more information regarding submission of NDC.*

Mail Order Incontinence Supplies

The state of Indiana has contracted with three vendors to provide all incontinence supplies via mail order to Indiana Medicaid members. This transition will begin in early 2008. Providers will play a key role by assisting members during this transition. Watch for additional information in upcoming publications.

All Durable Medical Equipment Providers

Claims Denied in Error to be Reprocessed

Claims billed between November 2, 2007, and November 15, 2007, for members enrolled in the *Medicaid Select* program were denied inappropriately for edits *1042 – Certification code is missing-Medicaid Select* and *1044 – Recipient's PMP is missing-Medicaid Select*. EDS will systematically reprocess the denied claims. Reprocessed claims will begin appearing on remittance advice statements beginning December 25, 2007.

All Medical, Institutional, and Pharmacy Providers

Eligibility Verification Systems Healthy Indiana Plan Update

Beginning January 1, 2008, limited information will be available on the IHCP Eligibility Verification Systems (EVS) regarding the new Healthy Indiana Plan (HIP). EDS will provide the following information for HIP members:

- The member's eligibility for HIP
- The member's insurer and telephone number
- The member's emergency room co-pay amount

To receive detailed HIP information on the Omni terminal, providers must download the most recent Omni software version after December 31, 2007. Download instructions can be found in Table 1.1 of provider bulletin *BT200711* on the IHCP Web site at http://www.indianamedicaid.com/ihcp/index.asp. If an Omni software download is not performed, only general HIP information is shown on the device. Information regarding the Healthy Indiana Plan can also be found in provider bulletin *BT200730*.

If you have questions about this article, call the Omni Help Desk at (317) 488-5051 in the Indianapolis local area or toll-free at 1-800-284-3548.

All Dental Providers

Audits for Bundled Services

Providers billing procedure codes *D1120, prophylaxis – child* and *D1203, total application of fluoride excluding prophylaxis – child* for the same member, on the same date of service will be reimbursed a bundled rate of $56.75. Providers billing procedure codes *D1110, prophylaxis – adult* and *D1204, total application of fluoride excluding prophylaxis – adult* for the same member, on the same date of service will be reimbursed a bundled rate of $70. Two new audits *6247 – Prophy and Fluoride Allowed a Maximum of $70.00 – Adult* and *6248 – Prophy and Fluoride Allowed a Maximum of $56.75 – Child* have been created and are effective for dates of service on or after January 1, 2008.

Dental Cap Audits

On January 1, 2008, dental code *D2390 – Resin-based composite crown, anterior*, will be added to the $600 dental cap audits. Dental claims received on or after January 1, 2008, billed with this code will be subject to audit *6236 – The member has exhausted a benefit limit for dental services. The limit for 21 and older is $600 per year for dental claims.*

Maximum Reimbursement for D7311 and D7321

Effective February 1, 2008, the IHCP will reimburse providers a maximum fee of $157.86 for *D7311, alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant*. The IHCP will reimburse providers a maximum fee of $198.94 for *D7321*, *alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant*. These changes will save providers claim processing time as cost invoices will not be required for reimbursement.

Claims Requirement for Dental Rendering Provider Information

Per IHCP banner page article *BR200701*, dated January 1, 2007, dental providers were notified of the requirement to include dental rendering provider information for claims received on or after April 15, 2007. This notice is to remind IHCP dental providers that this requirement refers to the date of receipt of the claim submitted, not the date of service on the claim. This requirement includes submission of non-check and check-related adjustments submitted by paper or replacements that are performed on Web interChange. If the claim or adjustment submitted does not include the appropriate rendering provider information, the claim will be denied with the following edits:

1. *231 – Rendering provider number is missing* – The entire nine-digit number must be used and must be in Field 24K. Provide and resubmit.
2. *232 – Rendering provider number is invalid* – The entire nine-digit number must be used and must be in Field 24K. Please verify and resubmit.

3. *1004* – Rendering provider not enrolled in the program billed for the dates of service. Please verify and resubmit.
4. *1008* – The rendering provider must be an individual provider. Please verify provider number and resubmit.
5. *1010* – Rendering provider is not an eligible member of the billing group or the billing provider is equal to the rendering provider. Please verify and resubmit.
6. *7509* – Rendering provider on prepayment review.

Note: For edits 231 and 232, Field 24K refers to CMS-1500 claim forms. For dental claims, the rendering provider number must be in the Administrative field.

The billing guidelines for the ADA 1999/2000 claim form are as follows:

1. *Group provider using a paper claim* – Enter the group number and location code. Enter the individual rendering provider number(s) in the Administrative column adjacent to each detail.
2. *Group provider using Web interChange* – Enter the group number and location code in the provider numbers field. Enter the individual rendering number in the Rendering Provider field.
3. *Individual billing provider using a paper claim* – Enter the individual billing number and location code in Field 44A on the ADA dental claim form. Enter the individual billing number in the Administrative field.
4. *Individual billing provider using Web interChange* – Enter the individual billing number and location code in the Provider Number field. Enter the individual billing number in the Rendering Provider field.

The billing guidelines for the ADA 2006 claim form are as follows:

1. ***Rendering NPI on the ADA 2006 dental claim form*** requires providers to indicate the rendering provider NPI in Field 54.
2. ***Rendering LPI on the ADA 2006 dental claim form*** requires providers to indicate the rendering provider Legacy Provider Identifier (LPI) in Field 58.

Providers can refer to the IHCP provider bulletin *BT200705*, dated February 13, 2007, for further information about billing guidelines for the ADA 2006 dental claim form.

In the event that your claim or adjustment request was denied with one of the aforementioned edits, your claim or adjustment request must be resubmitted with the necessary corrections.

In the event that a mass adjustment (claims that begin with region 56) is initiated by EDS for erroneously denied claims and the claim was originally paid based on a date of receipt prior to April 15, 2007, and the claim suspends for a rendering provider number edit, the claim will be forced. If the mass adjustment is processed and the original date of receipt is after April 15, 2007, the claim will be denied appropriately.

Contact Information

If you have questions about the articles published in this banner page, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, unless otherwise noted.

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