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All Providers

Don't risk claim rejection or denial!

National Provider Identifier (NPI) Update – **Beginning March 1, 2008**, your **claim will deny** if you are a healthcare provider and you submit a claim without a billing provider NPI! Only atypical providers and First Steps and Pharmacy claims are exempt from this deadline.

Accepted Claim Forms – **Effective March 1, 2008**, only the CMS-1500 (08-05 version), UB-04, and ADA claim form (2006 version) will be accepted for claims. Older versions of these forms, such as CMS-1500 (12/90), UB-92, or the ADA claim form (2000/2002 version), **will be returned to the provider** causing delays in claim processing.

Legacy Provider Identifier (LPI) Deadline – **Effective May 23, 2008**, your Indiana Medicaid LPI **will not be accepted** on claims. If you are a healthcare provider, any claim **received** on or after May 23 that uses an LPI **will be denied**. Refer to bulletin *BT200809* for more information.

Provider Enrollment Forms Notice

Provider Enrollment implemented new Indiana Health Coverage Programs (IHCP) applications and profile maintenance (update) forms effective September 27, 2007. Forms are available at http://www.indianamedicaid.com/ihcp/index.asp. Old forms are not being accepted for processing on or after January 1, 2008. Any previous version of the applications and maintenance forms submitted for processing after that date are being returned to providers with a request for completion and submission of a current form.

All Dental Providers

Dental Paper Claim Form Billing Clarification

Provider bulletin *BT200705* outlined the new American Dental Association (ADA) 2006 paper claim form changes and requirements. The bulletin stated the patient name is entered in *Form Locator 20 – Patient Name* and Patient Recipient ID is entered in *Form Locator 23 – Patient ID/Account #.*

A large number of dental claims have denied because the patient name was submitted in *Form Locator 12 – Policyholder/Subscriber Information* and the patient recipient ID was submitted in *Form Locator 15 – Policyholder/Subscriber ID*.

Medicaid now accepts the information for patient name in *Form Locator 20* or *12* and *Patient Recipient ID* in *Form Locator 23* or *15*. The claims processing system has been changed to meet the new requirements.

Nursing Facility Providers

Mass Adjustment of Medicare Part A Crossover Claims

EDS will process a mass adjustment of Medicare Part A crossover claims with dates of service from October 1, 2001 through March 26, 2002. During this time an emergency rule was in effect that capped Medicaid reimbursement of crossover claims at the Medicaid allowable rate. The State was sued and prevented from implementing this emergency rule as well as three others. On appeal, the court found in favor of the State and sent the case back to the trial court for a determination of the amount the State was owed in restitution from providers (See *IFSSA v. Amhealth et al*, 790 N.E.2d162).

The lawsuit involved the nursing facility industry's challenge of four emergency rules that, in aggregate, reduced Medicaid reimbursement. As a result of a settlement with the plaintiffs, only Medicare Part A crossover claims will be adjusted and recouped from nursing facility providers.

The adjustments will begin appearing on the March 18, 2008 remittance advice (RA). These claims will have an ICN number starting with **56**, which reflects a mass-adjusted claim. An accounts receivable (A/R) will be set up to recover the overpayment. Following review of the RA, providers who disagree with any adjustment amounts may request an administrative review by writing to the following address:

EDS Administrative Review
Written Correspondence
P.O. Box 7263
Indianapolis, Indiana 46207-7263

In the request explain why you disagree with the adjustment amount and include copies of all pertinent documentation. Detailed information about the administrative review process is available in the *Indiana Health Coverage Programs* (IHCP) *Provider Manual*.

All Mental Health Providers

Expediting Claims for Dually Eligible Members

It is now possible for providers to expedite claim payment for members that are dually eligible for Medicare and Medicaid when modifiers HE or HO are appended to the procedure billed. Providers can now use the *Claim Notes* field or segment on an 837P transaction instead of submitting a paper claim with attachments. This process should only be used by providers who are not approved to bill Medicare. The text entered in the *Claim Notes* field or the 837P segment should read, "Provider not approved to bill services to Medicare". This allows the claim to suspend for review of the *Claim Note* field or the 837P segment and the claim is adjudicated accordingly.

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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