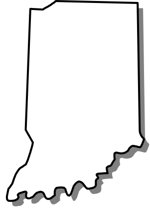

BANNER PAGE

BR200527 JULY 5, 2005

To All Providers:

- It is important that providers adhere to all filing limits guidelines during the implementation of electronic voids and replacements. If ***the date of service of a replacement*** is beyond the one year filing limit, the provider should submit the replacement via paper to the EDS Adjustment Unit and include the appropriate documentation.

  Currently, the Indiana Health Coverage Programs (IHCP) accepts electronic replacements according to the last activity of the original claim; however, replacement claims are still subjected to the filing limit edits. Therefore, if any dates of service are beyond the one year filing limit when the replacement claim is processed, edits 512 or 545 will post stating, "***Claim Past Filing limit***"

  If a provider's records indicate that a replacement has generated a claim correction form (CCF) due to the filing limit, the provider should submit the proper documentation for processing along with the CCF. If the provider does not send the documentation within 45 days of receipt of the CCF, the replacement claim auto-denies and the system generates an account receivable (AR).

  Do not submit any electronic voids on a replacement claim in CCF status. Voiding a replacement that is in CCF status could result in a denied claim and an AR.

- In an effort to benefit IHCP providers, the IHCP delayed the June 22, 2005, implementation of the system modifications that would post the Medicare denied service lines as denied service lines. This updates information published in IHCP provider bulletin *BT200511, HIPAA Modifications*, June 1, 2005.

  This modification is being delayed because the IHCP does not currently receive Medicare electronic crossover claims in the 837 COB format. Therefore, the IHCP continues to adjudicate Medicare denied service lines and reflect a paid status. To remove the paid status from denied service lines, a provider should continue using the adjustment process before resubmitting claims as Medicaid fee-for-service claims.

  The IHCP is working with the Medicare intermediaries and carriers to obtain electronic Medicare Part B crossover claims in the 837 COB format to eliminate the need for providers to submit adjustments to previously adjudicated claims.

  When the IHCP begins processing electronic crossover claims in the 837 COB format, the IHCP will implement the system modifications necessary to post the Medicare denied service lines as denied service lines. Additional information about these system modifications will be published in future banner page articles or newsletter articles.

To All Dental Providers:

- During the week of June 6, 2005, the IHCP identified a high number of claim denials for edit *1008 – rendering provider must have an individual number*. This error occurs when a provider submits a billing group number in the detail line. Per IHCP provider bulletin *BT200511*, published June 1, 2005, all group providers must use their rendering provider numbers. To expedite claims, providers should follow these guidelines:
  - **Group provider using a paper claim** – Enter the group number and location code(s) in field 44A. Enter the individual rendering number(s)in the Administrative column adjacent to each detail submitted.
  - **Group provider using Web interChange** – Enter the group number and location code in the provider number field. Enter the individual rendering number in the rendering provider field.
  - **Individual billing provider using a paper claim** – Enter the individual billing number and location code in field 44A. Enter the individual billing number in the Administrative column adjacent to each detail submitted.
  - **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.

- Providers who have Administrator access in Web interChange can view their provider profiles to access a list of the rendering providers linked to the group. Providers can also call the Provider Enrollment Helpline at 1-877-707-5750 to discuss any updates that need to be made to the provider group information.

To Medical Review Team Providers:

- This article deletes lines 2 and 3 of *Table 1 - The Medical Review Team (MRT) Procedure Codes and Fee Schedule* published in IHCP Provider bulletin BT200514 and replaces the 96100 SE U1 and 96100 SE U2 with the following:

MRT Code	Replacement Code	Description	MRT Rate
Psychological Testing /IQ Eval 1 Unit = 1 Hour Max Units: 2 Hours (Partial Unit Billing Allowed)	96100 SE	**96100**: Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour **SE**: State and/or Federally funded programs/services	$80.00 per hour

To MRT and Pre-Admission Screening and Resident Review Providers:

- This article replaces information in IHCP provider bulletins, *BT200513* and *BT200514* for form locator 24A in *Table 2 – CMS-1500 Claim Form Locator Descriptions.* Providers **should not bill** date ranges, but only for the single date of service. For example, if a provider renders services on June 30, 2005, and July 1, 2005, then the provider must bill each date of service as a separate line item on the claim. The provider **cannot bill the service on one line** using the date range of June 30, 2005, to July 1, 2005.

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