

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.

Bank Mergers and Closures May Cause Confusion

During recent months, a number of bank mergers and closures have been affecting providers who are currently set up for electronic funds transfer (EFT).

EDS must have an updated, signed IHCP Electronic Funds Transfer Addendum from the provider to change or update the EFT account information. In the event that the provider's bank account number and/or bank routing number is changed, or the provider's bank is no longer in business, the provider's EFT payments will fail to be processed by the bank(s).

If the provider has not sent updated EFT information to EDS, EDS will take corrective action as outlined below:

- The EFT account will be canceled, thus changing the provider payment option to paper check, until the appropriate documentation is received from the provider.
- The check will be sent to the "Pay To" address listed in the Provider File.

Note: If an incorrect "Pay To" address is in the Provider File, the paper checks will be misdirected.

To ensure that all provider file information is correct, providers may go to Web interChange and check under the Provider Profile link. Having the ability to review your Provider File information is another valuable tool offered through Web interChange.

Avoid Claim Denials under NPI

Avoid full claim denials when Phase III of National Provider Identifier (NPI) is implemented on May 23, 2008. The IHCP will send additional publications regarding the changes for Phase III implementation of NPI in the near future.

One of the requirements for billing with the NPI is to include the billing service location ZIP Code+4 on all claims. This requirement allows for a one-to-one match of the NPI with the legacy provider identifier in the claims processing system. The billing provider's service location is defined by the IHCP as the physical address where the service was rendered, NOT the address where billing occurs, or where payments are mailed.

NPI edit 1108 – Billing NPI has no matching LPI indicates either the NPI on the claim has not been reported, or the claim was not submitted with a matching *service location* ZIP Code+4. If a provider has more than one service location within the same ZIP Code+4, the claim must have the ZIP Code+4 and a distinct taxonomy code.

The ZIP Code+4 of the service location is required on all paper and electronic on claim transactions. Requirements were provided in the bulletins listed in Table 1.

Table 1 – Bulletins with Paper Claim Form Requirements

Provider Type	Field Locator	Bulletin Number
Dental	48	BT200705
Medical	33	BT200703
Institutional	1	BT200702

Edit 1108 is currently a *post and pay* edit, which does not cause a claim denial. However, we are quickly moving to Phase III of the NPI implementation. In Phase III this edit will cause **full claim denial**. A warning message has been added to other EOB messages to emphasize the importance of correct NPI billing. A date has not been announced for the implementation of Phase III at this time; however, providers are encouraged to register and/or verify the accuracy of their NPI and service location address now to avoid full claim denials when Phase III is implemented.

The ZIP Code+4 submitted on all claims to the IHCP must match the ZIP Code+4 for the *service location* on the provider enrollment file database. Web interChange users can verify the enrollment file

information using the Provider Profile *Name/Address* screen.

NPI Edit 1128-*Rendering provider NPI not registered with IHCP. Future claims may not pay* indicates that the rendering provider NPI has not been reported. When Phase III is implemented, these claims will deny.

Providers are encouraged to resolve **all** NPI edits appearing on the IHCP remittance advice (RA) prior to implementation of Phase III to avoid denials.

Voids and Replacements

An adjustment request for a previously paid claim can be submitted only when an incorrect or partial payment has been made on a claim, including a claim that incorrectly paid zero dollars. Please note that claims in **denied** status **cannot** be adjusted.

The denied claim must be submitted as a new day claim. In addition, line item denials for paid CMS-1500, Pharmacy, and American Dental Association (ADA) Dental Claim forms can be billed as a new claim to the correct claims processing address. Therefore, it is not necessary to submit denied line items of paid claims as an adjustment. Please refer to the *IHCP Provider Manual, Chapter 10*, for exceptions to this policy.

Providers are reminded that when a paper adjustment request is submitted to the Adjustment Unit for processing, the request is reviewed for the following information:

- The claim internal control number (ICN) represents the most recent activity for the claim to be adjusted.
- If the claim or detail has been denied for a benefit limitation audit, the claim cannot be processed through the Adjustment Unit.
- If additional units are requested, the billed amount for the service is also increased to reflect the appropriate billed amount for the units on the claim.
- Each claim must have its own adjustment request form.
- The adjustment request represents all changes for the claim. Providers cannot submit multiple adjustment forms to perform multiple changes on the same claim.
- A third-party liability (TPL) Explanation of Benefits is attached to support changes in the TPL amount.
- Adjustment requests submitted beyond the one-year filing limit include past filing documentation.

As a reminder, providers are always encouraged to perform voids and replacements to paid claims by using Web interChange.

Dental Provider News

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:

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

- 232 – *Rendering provider number is invalid* – The entire nine-digit number must be used and must be in Field 24K. Please verify and resubmit.
- 1004 – *Rendering provider not enrolled in the program billed for the dates of service*. Please verify and resubmit.
- 1008 – *The rendering provider must be an individual provider*. Please verify provider number and resubmit.
- 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.
- 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:

- *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.
- *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 on the ADA dental claim form.
- *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:

- *Rendering provider NPI* – Report in Field 54.
- *Rendering provider legacy provider identifier* – Report 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.

Pharmacy Providers

Removal of the Federal Upper Limit

Effective January 30, 2008, the Office of Medicaid Policy and Planning (OMPP) is changing the reimbursement policy for legend drugs. The new policy removes the federal upper limit (FUL) pricing from the IHCP reimbursement calculation. Aggregate reimbursement requirements, as required by the

Centers for Medicare & Medicaid Services (CMS), will be satisfied by the application of rates established through the State maximum allowable cost program (State MAC).

All pharmacy claims with a date of service on or after January 30, 2008, will follow the updated reimbursement policy.

Provider Workshops

2008 First Quarter Medicaid Provider Workshops

The IHCP offers workshops free of charge. Sessions are offered at several locations in Indiana. Table 2 lists the time, session topic, and description. The schedule allows for a lunch period from 12:30 p.m. until 1:30 p.m.; however, lunch is not provided.

Seating is limited in all locations. Registrations are processed in the order received and registration does not guarantee a spot at the workshop. Confirmation letters are sent upon receipt of registrations. If a confirmation letter is not received, the workshop seating capacity has been reached.

Workshop registration dates, registration deadlines, and locations are listed in Table 3. All workshops begin promptly at 8 a.m., local time.

General directions to workshop locations are

available on the IHCP Web site at <http://www.indianamedicaid.com/ihcp/ProviderServices/workshops.asp>. Consult a map or other location tool for specific directions to the exact location.

Seating for the workshops is limited to two registrants per provider number.

Providers may register online at www.indianamedicaid.com. If you do not have Internet access, a copy of the *Provider Workshop Registration* form is included in this newsletter. Print or type the information requested on the registration form. List one registrant per form. Fax completed registration forms to EDS at (317) 488-5376. EDS processes registrations chronologically based on the date of the workshop. The *Provider Workshop*