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To All Providers:

- With the implementation of Electronic Voids and Replacements, it is important that providers adhere to all filing limits guidelines. If ***the date of service on a replacement claim*** is beyond the one year filing limit, providers should submit the replacement via paper to the EDS Adjustment Unit with the appropriate documentation to avoid inadvertent recoupment of the entire claim paid amount.

  IHCP policy on filing limit indicates that claims must be submitted within a year from Date of Service (DOS). Prior to the implementation of Electronic Void and Replacements (EVR), claims submitted past the filing limit were reviewed by a claims resolution clerk. If the DOS was over a year old and no documentation was submitted with the claim, the claim was rejected and no adjustment made.

  With the implementation of EVR, providers may void a claim electronically without regard to the one-year filing limitation. However, if a replacement claim is submitted and the DOS is past the one year limit, the claim suspends for filing limit edits. Providers receive a CCF status and are asked to provide documentation to support waiving the filing limit. If the documentation is not received within 45 days of the CCF, the claim will deny for all services instead of being rejected as in the previous process.

  A system modification to reject claims over the year filing limit is currently being completed. Until this system modification is implemented, providers who wish to make adjustments to claims over 1 year old must either provide the documentation when the claim CCFs or submit the replacement claim on paper. Failure to take one of these actions will result in the entire payment for that claim being recovered by the program. Further instructions will be given to providers when the system modification is complete.
- The passage of *House Enrolled Act (HEA) 1325* has created some confusion. Some advocates and industry representatives have been disseminating information that Prior Authorizations and other clinical edits on behavioral health drugs covered through the Hoosier Healthwise Managed Care Organizations (MCO) are invalid as of July 1, 2005. However, that information is inaccurate.

  HEA 1325 confers upon the Mental Health Quality Assurance Committee the responsibility to make recommendations to the Office of Medicaid Policy and Planning (OMPP) regarding access to behavioral health drugs through the Indiana Medicaid program. The OMPP has the ultimate responsibility for implementing any restrictions with the advice of the Committee. The Mental Health Quality Assurance Committee is currently being assembled in accordance with the guidelines set forth in *HEA 1325*.

  Until the committee is formed and the OMPP issues guidance regarding access to behavioral health drugs by Hoosier Healthwise members in the Risk-Based Managed Care program, all MCO preferred drug lists (PDL) clinical edits will remain in effect.

To Ancillary and Medical Services Providers:

- Effective **August 2, 2005**, all providers that anticipate performing, or that perform, ancillary and medical services to Medicaid members during an inpatient stay at a State Hospital should contact the State Hospital to receive reimbursement. When patients who are enrolled in Medicaid receive services at a State Hospital, the State Hospital is responsible for all of the ancillary and medical costs incurred during the Medicaid member's stay. IHCP will deny any claim requesting reimbursement for ancillary treatment and all medical services while the Medicaid member is an inpatient at the State Hospital.

To Community Mental Health Centers and Mental Health Providers:

- This notification clarifies requirements regarding supervision of outpatient mental health or Medicaid Rehabilitation Option (MRO) services, as set out in *405 IAC 5-20-8* and *405 IAC 5-21-6*.

  The supervising physician, psychiatrist, or Health Service Provider in Psychology (HSPP) must see the patient during the intake process or review the medical information obtained by the mid-level practitioner, and must approve the initial treatment plan within seven days. Providers have requested clarification about IHCP policy regarding services provided within the first seven days of intake, but prior to the treatment plan being approved. The following scenario is provided to illustrate the concern.

A case manager or mid-level mental health provider assesses the member on Day 1. Based on this assessment, a treatment plan is developed and services are initiated on Day 3. The HSPP reviews and approves the treatment plan on Day 7.

The Office of Medicaid Planning and Policy (OMPP) has determined that it is appropriate for outpatient mental health and MRO providers to bill for medically necessary services that are provided prior to the approval of the treatment plan, as long as the treatment plan is signed within seven days of intake. If the treatment plan is not signed within seven days of intake, providers may not bill for services provided after day 7, until the treatment plan is signed.

To All Crossover Part B Providers:

- System modifications were implemented in May 2005 for claims that were billed with a modifier type indicating "processing" or "pricing" and paid incorrectly. The billing provider number was erroneously populated in the rendering provider number field on crossover claim submissions, causing the system to process claims and pay an incorrect rate. Not all claims that were billed with a processing or pricing modifier were affected.

  For claims that processed between October 1, 2003, and June 3, 2005, a mass adjustment will be performed on or after **August 30, 2005,** for incorrectly paid claims only. In the event you feel that your claim was paid incorrectly and it was not included in the mass adjustment, you may submit your own adjustment request for consideration.

  Administrative Review and Appeal

  The mass adjustment amounts will be reflected in the weekly remittance advice (RA) and will be assigned to region 56. Providers who disagree with the adjustments may request an administrative review by writing to the following address:
  EDS – Administrative Review
  Written Correspondence
  PO Box 7263
  Indianapolis, IN 46207-7263
  The request should include an explanation of the reason for disagreement and include copies of all pertinent supporting documentation. Refer to *Chapter 10, Section 6* of the *IHCP Provider Manual* for more information about the administrative review and appeal process.

To All Dental Providers:

- This notification reminds providers of the requirements for completing the *American Dental Association (ADA) 2000 dental claim form*. Please pay special attention to the fields, **Total Fee**, **Payment by other plan**, and **Patient pays.**
  The **Total Fee** field must be completed for all claims and should indicate the total of all individual service line charges.
  - The **Payment by other plan** field must be completed to reflect third party liability (TPL) payments only.
  - The **Patient pays** field must be completed only on claims for which a TPL payment has been received. This field indicates the net charge. Failure to indicate a net charge in the **Patient pays** field will result in a claim denial with the explanation of benefits (EOB) 401 – Net charge is missing.

  For claims that **do not** include a TPL payment, providers are not required to complete the "Payment by other plan" field or the "Patient pays" field.

To Pharmacies and Prescribing Providers:

- Effective January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.
  The IHCP will provide information as it becomes available with banner pages, the IHCP provider newsletter, bulletins, and the IHCP Web site. The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare Prescription Drug Benefit.
  For more information about the Medicare Prescription Drug Benefit visit the CMS Web site at http://www.cms.gov/medicarereform/