Indiana Health Coverage Programs

B A N N E R P A G E

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To All Providers:

- Indiana Health Coverage Programs (IHCP) reimbursement rates are subject to a two percent reduction for dates of service effective February 15, 2005, through June 30, 2005, pursuant to the Medicaid office's emergency rule to avoid an anticipated budgetary shortfall and to remain within the available Medicaid appropriation. If any funds remain at the end of State fiscal year 2005, amounts up to the two percent reduction will be proportionately distributed to providers.
  Disproportionate share hospital (DSH), safety net, Health Care for the Indigent (HCI) add-on, upper price limit (UPL), state facility, Medicaid Rehabilitation Option (MRO), transportation, and Primary Care Case Management (PCCM) payments are excluded from the reduction.

- With the recent implementation of Membership and with new functionality being added to Web interChange in the near future, organizations that use Web interChange should designate and apply for a Web interChange administrator if they do not already have one. Organizations using Web interChange that do not have an administrator will not have access to new functionality when it becomes available. The new functionality includes provider profile inquiries, provider profile maintenance, and prior authorization inquiries and requests.
  The following are additional advantages of having an administrator:
  - Ability to create and maintain users within an organization. Each user chooses their own user identification and password.
  - Ability to reset passwords for users within an organization.
  - Ability to assign specific Web interChange access rights to users within an organization. Each user has access to only the information that the administrator assigns to them.

  For information about setting up an administrator, users should click on the How to Obtain an ID link from Web interChange at https://interchange.indianamedicaid.com.

- Health Insurance Portability and Accountability Act (HIPAA) security regulations require Web interChange users to change login passwords every 90 days. This HIPAA regulation has been implemented; therefore, as early as February 14, 2005, Web interChange users will be directed to change their existing Web interChange password. Users may change their Web interChange passwords prior to the 90-day notification by clicking on the Change Password link from Web interChange. New passwords must be compliant with HIPAA password standards. The Frequently Asked Questions link from Web interChange at https://interchange.indianamedicaid.com describes the HIPAA password format standards. Providers should refer questions about Web interChange password regulations to the Electronic Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.

- This article is to clarify and update IHCP policy regarding Healthcare Common Procedure Coding System (HCPCS) code *V2785 – Processing, preserving, and transporting corneal tissue.* The IHCP currently provides reimbursement for HCPCS code V2785 separate from the ambulatory surgical center (ASC) rate for outpatient corneal transplant procedures. Current policy instructs providers to bill this code on the UB-92 claim form with revenue code *362 – Organ/Tissue Transplant.*
  Effective for claims filed on February 1, 2005, and after, the IHCP will require providers to bill HCPCS code V2785 on the CMS-1500 claim form or 837P transaction for reimbursement separate from the ASC rate for outpatient corneal transplant procedures. A copy of the invoice from the eye bank or organ procurement organization showing the actual cost of acquiring the tissue must be attached to the claim form. When submitting paper attachments with an 837P transaction, providers must follow the instructions provided in the *IHCP Provider Manual*, Chapter 8, Section 1. The IHCP will reimburse providers 90 percent of the invoice amount. Providers should direct additional questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

- This article advises providers of changes in IHCP policy regarding positron emission tomography (PET) scan billing. IHCP is limiting reimbursement to specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes. Providers should bill PET scans using an appropriate HCPCS code and ICD-9-CM diagnosis code, as listed in Table 2 below.
  As of the March 1, 2005, the IHCP will no longer reimburse for Current Procedural Terminology (CPT®) *78459 – myocardial imaging, PET, metabolic evaluation.* Providers are advised to bill this service using HCPCS code *G0230 – PET imaging; metabolic assessment for myocardial viability following inconclusive SPECT study.* All other billing requirements for

reimbursement of PET scans remain unchanged. Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Table 1 – ICD-9-CM Codes Supporting Medical Necessity

PET Scan Imaging	HPCPS Code	ICD-9-CM Code
Myocardial perfusion imaging	G0030, G0031, G0032, G0033, G0034, G0035, G0036, G0037, G0038, G0039, G0040, G0041, G0042, G0043, G0044, G0045, G0046, G0047, G0230	411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.8, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05
Regional or whole body, for single pulmonary nodule	G0125, G0234	235.7, 239.1, 793.1, V71.1
Whole body, for non-small cell lung carcinoma	G0210, G0211, G0212, G0234	162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 196.1, V10.11, V71.1
Whole body, for colorectal cancer	G0213, G0214, G0215, G0231	153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 197.5, V10.05, V10.06, V71.1
Whole body, for melanoma	G0216, G0217, G0218, G0233	172.0, 172.1, 172.2., 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82, V71.1
Whole body, for lymphoma	G0220, G0221, G0222, G0232	200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, V10.71, V10.72, V10.79, V71.1
Whole body, or regional, for head and neck cancer	G0223, G0224, G0225	140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 170.0, 170.1, 171.0, 173.0, 173.1, 173.2, 173.3, 173.4, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 194.1, 194.3, 194.4, 194.5, 195.0, V10.01, V10.02, V10.12, V10.21, V10.22, V10.81, V10.83, V10.84, V10.89, V71.1
Whole body, for esophageal cancer	G0226, G0227, G0228	150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, V10.03, V71.1
Refractory seizures	G0229	345.01, 345.11, 345.2, 345.3, 345.41, 345.51, 345.61, 345.71, 345.81, 345.91
Breast Cancer	G0252, G0253, G0254	174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6 174.8, 147.9, 175.0, 175.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1
Thyroid Cancer	G0296	193

To All Hospital Providers:

- Hospital providers may have noticed claims denying for edit *4099 – DRG not on file*, for inpatient newborn claims. These claims denied inappropriately from January 17, 2005, through January 24, 2005. The IHCP will reprocess these claims and they will appear on the February 8, 2005, remittance advice (RA). Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To All Durable Medical Equipment Providers

- Effective February 15, 2005, medical supplies, non-medical supplies, and routine durable medical equipment (DME) items billed to the IHCP for members residing in long-term care facilities will deny. Long-term care facilities include nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and community residential facilities for the developmentally disabled (CRFs/DD). The IHCP policy stipulates that providers cannot bill the IHCP directly for medical supplies, non-medical supplies, or routine DME items provided to an IHCP member residing in a long-term care facility. The costs for these services are included in the facility per diem rate, and the medical supplier, or DME company should bill the long-term care facility directly for such services. For further information, refer to *405 IAC 5-13-3* and *405 IAC 5-31-4*.

  HCPCS codes for medical supplies, non-medical supplies, or routine DME items billed to the IHCP for members residing in long-term care facilities will deny with explanation of benefit (EOB) code *2034 - Medical and non-medical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to the IHCP*.

To All Dental Providers:

- IHCP provider bulletin *BT200433*, published December 23, 2004, stated that procedure code *D7283 – placement of a device to facilitate eruption of an impacted tooth*, was a covered service effective January 1, 2005. Further review indicates that this procedure is performed as an orthodontic service. The IHCP covers comprehensive orthodontic services with prior authorization (PA), as outlined in IHCP provider bulletin *BT200230*, published June 19, 2002. Procedure code D7283 includes placement of an orthodontic bracket or band to facilitate eruption of an unerupted tooth after surgical exposure. Placement of an orthodontic bracket is included in the reimbursement for comprehensive orthodontic services; therefore, procedure code D7283 is not separately reimbursed. Providers should direct questions about this article to the Health Care Excel (HCE) Medical Policy Department at (317) 347-4500.

To All Outpatient Hospitals and Ambulatory Surgery Centers:

- Upon implementation of the new outpatient reimbursement policy as stated in IHCP provider bulletin *BT200420*, published September 15, 2004, the IHCP discovered a payment issue related to outpatient surgeries. When providers billed only one surgery or one unit of service, the system calculated the rate at 150 percent instead of 100 percent. This calculation resulted in overpayments. This impacted outpatient claims with paid dates from October 5, 2004, through November 9, 2004. Therefore, the IHCP will initiate a systematic mass adjustment for all affected claims. Providers can expect adjusted claims to appear on the RA statement dated March 8, 2005.